Maryland
STATE MEDICAL JOURNAL

*Medical and Chirurgical Faculty of the State of Maryland*

VOLUME 6 | *March, 1957* | NUMBER 3

# EDITORIAL

*Editor's Note:—This issue attempts to portray the history and future plans of Mercy Hospital in Baltimore. The spirit of cooperation, goodwill, enthusiasm and service that pervades this voluntary, religious institution is in such sharp contrast to the impressions expressed in this letter from London, England, that it is being published in lieu of an editorial. I believe that it speaks for itself.*

London, England
January 5, 1957

The next subject I would like to call to your attention is the socialistic system of medicine. Here are a few facts I learned which were most interesting. A physician can have 2,500 patients on his panel. From each of these the physician receives 17 shillings/year. His maximum income would be £2125 or $5,950.00. I think the cost to each person is a Health Tax of 3 shillings/week or $21.84/year. (This figure I cannot guarantee.) In addition, the patient pays 1 shilling (14 cents) for each item written for by prescription. The tax on an income between £2000 and £2999 is 50%. All above £2999 is taxed at 19/6 per 20 shillings. As you can see, there is no financial incentive for the profession to ask for a larger panel. Their fight at present is to get an increase in pay with a reduction in panel load. This is the only way to increase their individual worth and also make more panels available for young physicians who have no place to practice. I met a young man who had qualified seven years ago, but as yet had no panel. He has had to take an instructorship at a teaching hospital with a salary of £750/year, roughly $2,250.00 to provide for a family of five. This salary is on a par with skilled labor (£468 for an oil loader, £624 for a secretary).

Every doctor who stays in a full time position increases the cost of medicine and decreases the amount of money available to the family physician who does the bulk of the medicine. The greatest part of all taxes paid for health are spent in the following categories: 1. administration, 2. hospitals, 3. ambulance service, 4. drugs. Each of these take a larger portion than that allotted the general practitioner. The board qualified physician *with positions* fare much better. None will accept a full-time position, most work 9/11ths, which means they take nine sessions (clinics, round or lectures) of the eleven deemed necessary as a fully employed specialist. These men then can do private practice in the remaining time. This not only supplements their income but by being a consultant of the health service they can extend their tax benefits to cover their private practice and many domestic expenses otherwise not deductible. Now after all these deductions, there is a point of little return for the specialist, also. These men do not desire a large practice, and their services are greatly in demand. In this group, with little competition and little incentive, I

feel the people again suffer because of the lack of a high standard of professional-patient relationship.

A worse part of socialized medicine is the slow but sure suicide this system enforces. Doctors are advising their children to take up other professions. Yes, the government is subsidizing some students from families otherwise unable to attend medical school. Some that I have met state openly that they are not primarily interested in Medicine, but in elevating their social stature and as they state, earn money the easy way. Some of the first of this type produced have already discovered that they have joined the ranks of civil servants and a profession devoid of its old prestige. The easy money has proven very scarce and their work is not nearly as easy as they expected. These men are no loss to the profession, but they are also the bulk of future English physicians. The older established physicians in a surprising number are also switching to business or immigrating. The young man just qualifying as a specialist is in even worse position. Most of these 9/11th positions were filled by young men returning from the service at the inception of the health scheme. These new specialists are feeding their families by working outside of medicine (one I know is a carpenter's helper, another a drug salesman) waiting for death to produce an opening before their own number is up. This is not Tory propaganda!! This is an impression gained by listening to those living these experiences—by chance meeting I have met men who fall into each category described.

Many of you reading this letter were shocked that young physicians even suggested the word "strike" in our system a few years ago. Last year at the British Medical Association annual meeting the physicians felt they were due for an increase in salary in keeping with the cost of living clause granted in the initial socialized health bill. The Minister of Health recognized the poor organization of this group and knowing that physicians had little experience in collective bargaining outmaneuvered them. After the meeting adjourned, he published his negative decision. The years grace did not stem the tide as he had expected. A careful study showed that the only government controlled wage group receiving a pay raise since the institution of the socialistic system were those that backed their claims by striking. So the physicians have armed themselves with the only weapon their government recognizes—they say 24% increase in wage, smaller panels & etc. or *STRIKE*. I have not time to discuss how they intend to carry this out without jeopardizing the critically ill, but put yourself in their place. Neither the Government nor Tory papers will carry their side to the people. Each physician is defending his stand at the bedside and in his office. The Minister of Health admitted that the government index showed a 24% increase in the cost of living, but stated that he would neither grant nor refuse the request. He said that such an increase would bankrupt the Commonwealth and secondly that no respectable physician would carry out the threat. I don't want to anticipate the outcome but I can tell you the profession has no more prestige than the postal clerk—less than the Bobby—that his financial standing is far below his years of training and sacrifice—professionally his future is not bright.

America can break socialized medicine in England and at the same time strengthen the profession at home. We should stop dollar grants for education and research to England, but offer the same dollars for these people to work within America. Open the doors of our profession to the best of their young men. We can stand and survive their competition and need their enthusiasm to prevent socialization in our country.

All energetic, imaginative and vital Englishmen are looking for wider horizons. Generally, 400 people each week apply for entry into Canada alone. For over 1 month, 3,000/day have been applying. When we have broken the Englishman's reserve, everyone we have met admitted that there was no future for their children in this socialistic system.

Thank God for what we have—and it is worth holding.

# PRESIDENTIAL LETTER

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**Medical and Chirurgical Faculty**
**of the State of Maryland.**
**1211 Cathedral Street.**
**Baltimore.**
ZONE - 1

March 1, 1957

MEMBERS OF THE MEDICAL & CHIRURGICAL FACULTY
OF THE STATE OF MARYLAND

Dear Doctor:

**The poliomyelitis vaccination program for 1956** has been completed. Review of statistical results shows that the vaccine has been effective in preventing the paralytic form of the disease. There were 15,000 cases reported in 1956, as compared with over 29,000 in 1955. A definite shift in the age distribution of paralytic cases in children occurred, with proportionately fewer cases in the 5–9 year old age group, upon whom early vaccination programs were concentrated.

Despite the obvious protection afforded by vaccination, the program lags. In our own State, only 28.2 per cent of the people (under 20 years) have received 3 injections.

While we recognize the hazards of poliomyelitis to the child, let us not forget that it is estimated that 25 per cent of the paralytic polio occurs in young adults. On January 1, 1957, only one per cent of the 20–35 year age in Maryland had been vaccinated, and this is the age group in whom, when paralytic polio strikes, economic disaster results.

Our physicians in the 1957 program have "a golden opportunity to once again demonstrate to the people of Maryland our sincere interest in furthering their health welfare." We are dedicated to promoting the health of our people, let us not be laggards nor be placed in the position where we can be accused of exploiting and obstructing.

The physicians of Maryland have a fine traditional background of providing medical leadership. Let us lead in this fight against poliomyelitis.

Our goal: 100 per cent coverage during "POLIO V DAYS."

*Sincerely yours*

C. Reid Edwards

C. REID EDWARDS, M.D.
President

CRE:gc

*CENTRAL COORDINATING COMMITTEE ON POLIO VACCINE* of the Medical and Chirurgical Faculty

Doctors J. EDMUND BRADLEY, *Chairman*, Baltimore; JOHN A. ASKIN, Baltimore; KATHERINE H. BORKOVICH, Baltimore; HARRY D. BOWMAN, Hagerstown; EDWARD DAVENS, Baltimore; ROBERT W. FARR, Baltimore; WILLIAM C. MORGAN, Salisbury

## ANNUAL MEETING—MEDICAL AND CHIRURGICAL FACULTY
## WEDNESDAY, THURSDAY, FRIDAY, MAY 1, 2, 3, 1957

Plan your shedule so that you will be able to attend the scientific and business sessions and social functions of the Annual Meeting, which have been arranged by the Committee on Scientific Work and Arrangements.

### BUSINESS SESSIONS

1211 Cathedral Street

The House of Delegates will meet on Wednesday and Friday mornings, and the Council on Wednesday morning. There will not be any business sessions on Thursday.

The House of Delegates will hold its meetings in Osler Hall of the Medical and Chirurgical Faculty Building. All members of the Faculty are most welcome, but only the delegates have the privilege of the floor. Attend these meetings so that you will be conversant with the activities of the officers and committees of your Association, and will know the work that is being accomplished for the people in Maryland, as well as the doctors, through your State Medical Society. The Council meeting, which will precede the House of Delegates, will be held in the Friedenwald Room of the Faculty Building.

### AUXILIARY LUNCHEON

Sheraton Belvedere Hotel

The Woman's Auxiliary to the Medical and Chirurgical Faculty will hold its annual luncheon at the Sheraton Belvedere Hotel on Wednesday, May 1. The doctors, their wives and guests are invited to attend.

### SCIENTIFIC SESSIONS

Osler Hall, 1211 Cathedral Street

There will be scientific sessions on Wednesday afternoon, all day Thursday, and Friday afternoon. Following are some of the speakers and their subjects:

*Out-of-State*

ROSE RUTH ELLISON, M.D., Cornell University Medical College—Chemotherapy of Leukemia.

KEITH S. GRIMSON, M.D., Duke University—Choice of Treatments for Peripheral Vascular Disease.

SAMUEL PROGER, M.D., Tufts University School of Medicine—Coronary Atherosclerosis.

R. H. O. B. ROBINSON, F.R.C.S., President, British Association of Urological Surgeons—Will give the Trimble Lecture.

GEORGE E. SCHREINER, M.D., Georgetown University—Indications and Use of the Artificial Kidney.

FREDRICK J. STARE, M.D., Harvard School of Public Health—Nutrition and Atherosclerosis.

WILLIAM D. STROUD, M.D., University of Pennsylvania—Rheumatic Fever and Rheumatic Heart Disease.

BARNES WOODHALL, M.D., Duke University—Modern Treatment of Acute Subarachnoid Hemorrhage.

*From Maryland*

LEO H. BARTEMEIER, M.D.—Influence of Patients on their Physicians.

IVAN L. BENNETT, JR., M.D.—Staphylococcal Infections.

ROBERT W. BUXTON, M.D.—Subject to be selected.

E. COWLES ANDRUS, M.D.
GEORGE G. FINNEY, M.D.
LOUIS KRAUSE, M.D.
—Panel Discussion, Myocardial Infarction versus Gall Bladder Disease.

WARDE B. ALLAN, M.D.
JOHN A. WAGNER, M.D.
—Clinical Pathological Conference.

*Annual Meeting continued on next page*

*1957 Annual Meeting Continued*

Your Annual Meeting Program, which will be mailed the latter part of April, will list the exact time these and additional papers will be given.

On Wednesday Evening there will be a Symposium arranged by Dr. Russell S. Fisher, Chairman of our Joint Committee with the Bar Associations on Medicolegal Problems.

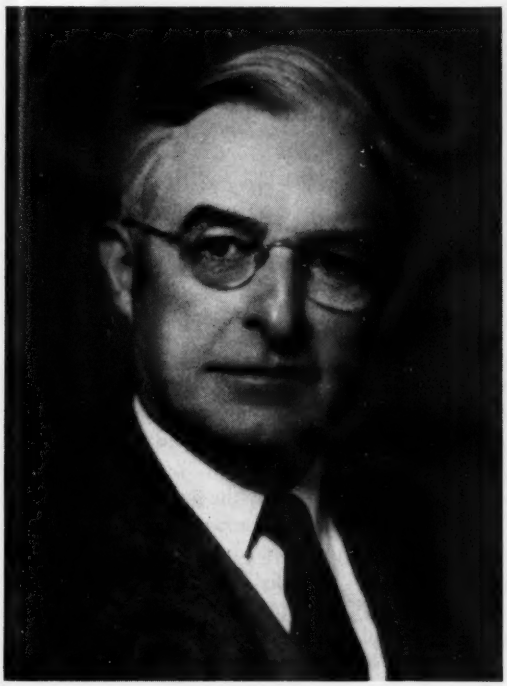
## ROUND TABLE LUNCHEON

The ever-popular Round Table Luncheon will be held again this year at the Sheraton Belvedere Hotel on Thursday, May 2. There will be twenty-three tables with moderators on various subjects of interest. A list of these subjects and the moderators will be mailed to you early in April. Be sure to make your reservation promptly!

## PRESIDENTIAL DINNER

Members and their guests are cordially invited to attend this dinner, which will be held at the Sheraton Belvedere Hotel on Thursday evening. Dress optional. Immediately preceding the dinner, the Baltimore City Medical Society will be host at a cocktail party for all those attending the dinner.

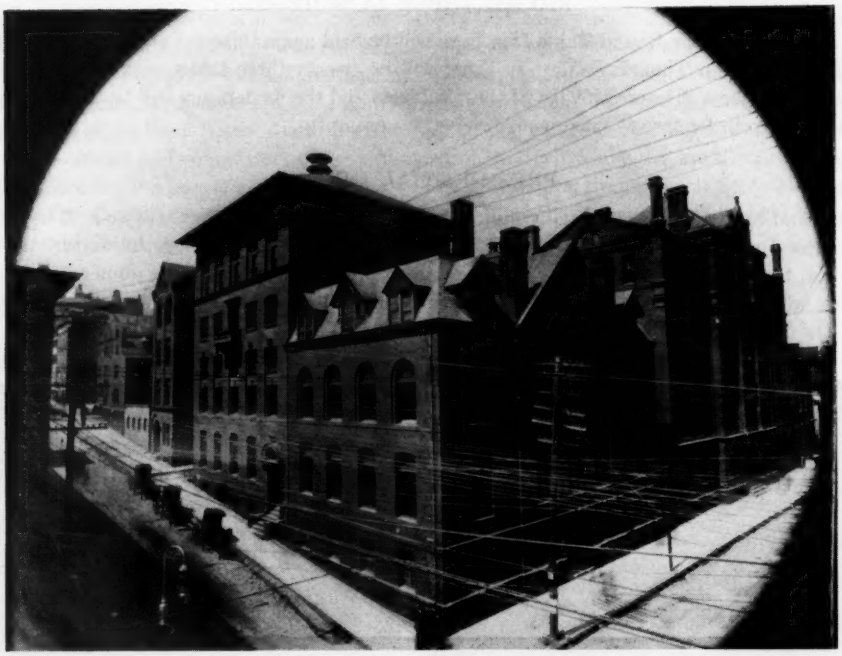
Members who cannot attend the dinner are invited to be present at the general meeting to hear the speakers, Dr. Dwight H. Murray and Dr. C. Reid Edwards.



Dr. C. Reid Edwards, President of the Medical and Chirurgical Faculty, will give the Presidential Address.

Dr. Dwight H. Murray, President of the American Medical Association, will give the Harvey Grant Beck Memorial Lecture, the title of which will be "Socio-Economic Issues Confronting Medicine."

# Mercy Hospital Issue



**MERCY HOSPITAL—ABOUT 1900**

The exact date of the above photograph is unknown, but it must have been taken around the turn of the century. It was before the 1911 building was added to the north of the central building, and it was after 1889 when the central building was erected.

The absence of automobiles, the three carriages with horses, the overhead wires and the gas street light place it at about 1900.

The building on the corner, which houses the accident department, the out-patient clinics, laboratories, etc., is believed to have been built more than a hundred years ago.

In 1869 it was being used as a public school and was condemned by the City and turned over to Washington University for use as a hospital and medical school. This was the origin of the College of Physicians and Surgeons. The central building bears an inscription on its cornerstone with the dates, 1888–1889.

**MERCY HOSPITAL—1956**

This picture was taken shortly before the erection of the new Commercial Credit Building on St. Paul Place. The 1911 building can be seen, and also, beyond it, the Nurses' Home and School of Nursing on Pleasant Street.

Although not legible in the photograph, from across Calvert Street there can be seen above the third story windows of the College Building the inscription in bold relief, "College of Physicians and Surgeons."

Outside of an additional small building which houses part of the power plant built in 1929, the decking over the first floor of the inner courtyard and the enclosing of the open balconies in the same courtyard, no construction has been undertaken at the hospital since 1911.

Without enlarging its facilities, this then is the hospital that has since 1910 tripled its admissions per year. Over the same span of time, accident room visits jumped from 1,775 to 15,902; obstetric deliveries from 206 to 2,700.

Other departments have likewise shown tremendous expansion in volume, although not in space.

The lack of adequate space and the antiquity of the buildings is the motivating force behind Mercy's building program.

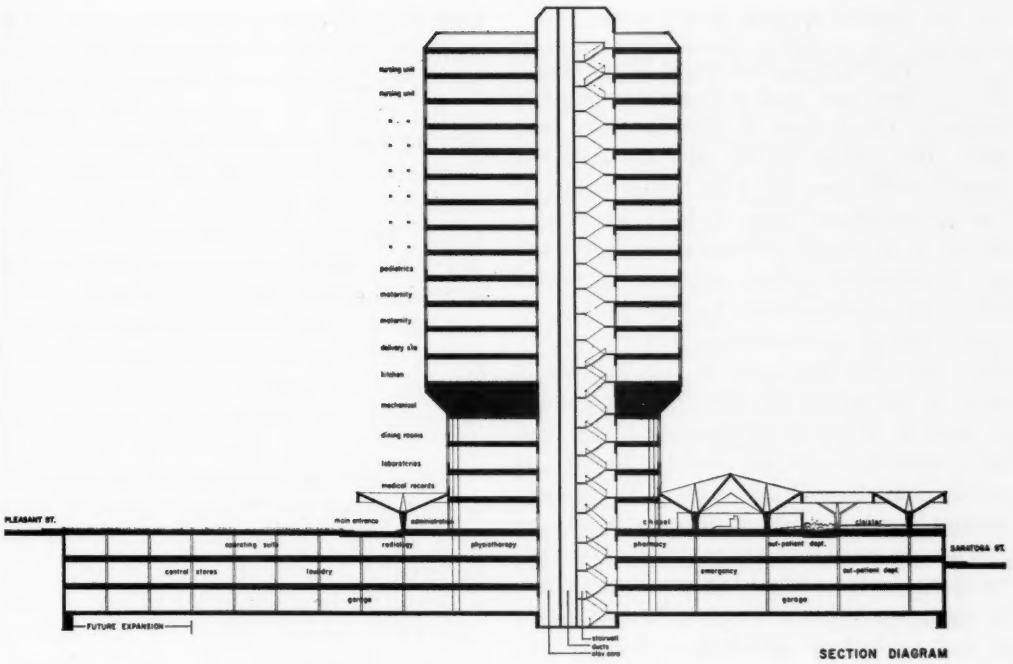
**MERCY HOSPITAL—195–?**

The artist's conception of the new Mercy Hospital has evoked much comment, including such remarks as "shocking." Such comments have been in the extreme minority. To most eyes the contemplated structure is daring, clean of feature and practical.

The shape of the building was dictated by the desire to have nursing units of between 40 and 45 beds. All of the upper floors of the tower have nursing units of 43 beds each. Every patient-room has an outside exposure, every bed has piped oxygen and direct two-way communication with the nursing station.

A service core extends from the ground floor to the roof. The nursing station is centrally located on each floor, and the square shape saves countless steps, since each room is easily accessible. Six express elevators will take care of hospital traffic, visitors and service.

The cantilever design is as old as Archimedes and will prove as lasting. It is no more top-heavy than two equal weights at either end of a plank laid across two sawhorses. The tower narrows at the bottom so that construction can proceed without tearing down the buildings that stand in that space at present.




## MERCY HOSPITAL—CROSS SECTION

It is understood that all of the plans for the new hospital submitted to date are still in a fluid stage. These are discussion plans rather than working plans. However, the above will give a general idea of the disposition of various departments.

The section shown in black, the fifth story above the base where the tower is cantilevered out, contains all of the mechanical equipment. Heretofore, this has been placed in the basement, or more recently, in order to utilize the basement for garage purposes, on the roof. It was felt that placing it here, approximately mid-way, was more efficient, more economical and being on a floor by itself, more out of the way.

In the base of the structure there will be nine operating rooms and suitable recovery rooms. The part marked on the extreme left of the base as "future expansion" is where the convent stands at present.

The building fund goal of $8,000,000 does not include provisions for the chapel as shown or for the School of Nursing which is not shown in the cross section, but which is the building in the foreground in the artist's conception of the new structure.

The building has 21 stories, counting the base; it is approximately 260 feet high and will contain between 350 and 400 beds.

# MEDICINE

H. RAYMOND PETERS, M.D.*

## The Past

The Department of Medicine at Mercy Hospital can indeed look back with great pride to its forebears. The College of Physicians and Surgeons, from which Mercy later evolved, was founded in 1872 by men of the highest calibre,—men acknowledged today to have contributed greatly to the science of their times. But above all, our founding fathers and their successors have been noted not only for their healing art but for the God-given zeal to impart their knowledge, skill and experience to the students of Medicine who would later carry on their work. It is, then, a source of gratification to us that, never since its incipiency has the Medical, as well as many other Departments at Mercy, been without its role of teaching medical students.

It is to be noted that, at the time of the founding of the College of Physicians and Surgeons and for many years thereafter, specialization had in no way reached the fine lines of cleavage seen today. The need for teachers in major branches was great but the number of such physicians was indeed sparse. To meet this emergency "Providence, as is Its wont," raised up specially gifted men of many faceted skills. It was thus not uncommon that we find one of these brilliant physicians an outstanding Professor of Medicine at one stage of his career but later serving as Professor of Surgery with similar acclaim. It was the good fortune of our institution that the Medical Department in its incipiency was manned by physicians of this high stature.

Among the very first pioneers may be mentioned Abram B. Arnold, who was the Professor of the Practice of Medicine at the Washington University, Baltimore, from 1872–77 and then became Professor of Nervous Diseases at the College of Physicians and Surgeons from 1877 to 1889. He is reputed to have been prolific in his contributions to the literature. In like manner, Harvey Leonidas Byrd was Professor of Practice at the College of Physicians and Surgeons, 1872–73, but later became Professor of Diseases of Women and Children. He was one of the founders of our institution, as was John S. Lynch. The latter was alternately Professor of Anatomy in 1872 and later Professor of Practice of Medicine until 1884. Dr. Lynch is credited with the first introduction of the drug, Antipyrine. While at first soundly criticised for its "dangers," later, when its dosage and administration were better understood, it came into wide use.

One of the truly outstanding figures at our institution was Dr. Thomas Sargent Latimer. Some of the positions he so ably filled were Professor of Anatomy at the Baltimore College of Dental Surgery, and at the College of Physicians and Surgeons, Professor of Histology and Pathological Anatomy. He was Professor of Surgery from 1872 to 1876. Following this he was Professor of Physiology and Diseases of Children until 1883. He completed his career as Professor of Medicine from 1883 until 1909. Some idea of the stature of this man may be gleaned from the fact that he not only won acclaim in each of his Professorships, but concomitantly took up duties as President of the College, was President of the Clinical Society of Maryland and found time to be Editor of two medical journals, in addition to being a contributor to many important textbooks of the day.

Certainly a name that adds lustre to our distinguished forebears is that of Dr. Nathaniel G. Kierle. He was Physician in Charge at the City Hospital Dispensary in 1881 and in 1894 was elected Professor of the Departments of Pathology and Medical Jurisprudence at the Physicians and Surgeons College. Following the monumental work of Pasteur against Rabies,

* Head of Department of Medicine, Mercy Hospital. Professor of Clinical Medicine, University of Maryland, School of Medicine.

Dr. Kierle developed ultimately his own strain of anti-rabies vaccine and instituted here one of the very first anti-rabies centers in the United States. This clinic began in 1879 and continued to 1915 when it was transferred to the State Health Department.

The Bressler Building, a part of the University of Maryland medical center at Greene Street is devoted to many and varied medical research projects. This fine edifice was the result of a magnificent bequest from Dr. Frank C. Bressler. Dr. Bressler was a House Officer here in 1885 and was later elected Associate Professor of Practice of Medicine at the Physicians and Surgeons College.

Dr. Samuel T. Darling worked at the College of Physicians and Surgeons from 1903 to 1905. In 1906 he was the first to describe Histoplasmosis and later was recognized as a world authority on Malaria.

Dr. William F. Lockwood was Professor of Materia Medica, Therapeutics and Clinical Medicine from 1899 to 1909 at the Physicians and Surgeons College. He was then appointed Professor of Medicine. He was one of the first to teach students at the bedside and preferred this to the prevalent system of scheduled lectures. The writer has always treasured the privilege he had of attending Dr. Lockwood on his rounds during his later years. His ability to come to an early and correct diagnosis after bedside examination was uncanny. In fact, Sir William Osler, who knew him well, is reputed to have once said that "Lockwood was the best 'snap-shot' diagnostician he knew."

Some years later, working alongside Dr. Lockwood as Chief Physicians of the Medical Service were Dr. Standish McCleary and Dr. Harvey G. Beck. Dr. McCleary, besides his clinical teaching and practice, was Pathologist to the institution for many years. His fine pathological acumen, as well as his dry wit will always be remembered. Dr. Beck was a most able teacher and practitioner. Always interested in the then cryptic subject of Endocrinology he became Professor of the specialty and lectured at the University of Maryland as well as here for many years.

Dr. Julius Friedenwald established the Department of Gastroenterology at the Physicians and Surgeons College in 1893 and was appointed Professor of the specialty in 1904. He was extremely prolific in his contributions to the literature, and later his patients, attracted from far and wide, filled the halls of Mercy. His book "Diet in Health and Disease," written with Dr. John Ruhräh, became a standard text.

Another outstanding figure at our institution was that of Dr. Andrew C. Gillis, who is still quite active in the field of Neuro-psychiatry. He was Professor of Neurology and Psychiatry at the Physicians and Surgeons College until 1916, and later gave distinguished service to the armed forces in World War I. On his return he served as Professor of Neurology at the University of Maryland from 1922 to 1949. His broad knowledge and wide experience gave him a clinical acuity which placed him high in his field. Dr. Gillis has been Emeritus Professor at the Maryland University since 1949.

## The Present

The writer begs leniency in his use of wide literary license in designating the "present" as a period extending back to 1922. It was in this year that Dr. Maurice C. Pincoffs was appointed Professor of Medicine at the University of Maryland, and in 1923 he accepted the position of Head of the Department of Medicine at the Mercy Hospital. His prior distinguished career at the Johns Hopkins School of Medicine was interrupted from 1917 to 1919 by his service as Captain in the Medical Corps, U. S. Army. After further brilliant work at the Johns Hopkins came his appointment as Professor of Medicine at the Maryland University and he took up the tremendous task of organization. Coming to us at Mercy a year later, he set about and quickly accomplished a similar reorganization. We like to believe that his task here was made a bit easier by the whole-hearted, friendly acceptance and

cooperation given by the retiring Heads of the Medical Service. Dr. Pincoffs soon had the teaching of medical students here well integrated with that at the University. For many years he taught students and house officers on the wards at Mercy and, down the years, there is none who does not treasure his hours with him. He inculcated in all, not merely his boundless medical knowledge, but instilled in many a part of his own high dedication to the ideals of Medicine. He could uniquely stimulate the ambition, energy and capacity for work in all his young men. Many of the house officers at Mercy have progressed upward through the years to Professorial rank at the University of Maryland, and indeed, several are now Heads of their Department at the University and elsewhere.

It is unfortunately impossible in the space here allotted to even mention the long list of Dr. Pincoffs' contributions to medical literature, much less his many accomplishments and all the high honors bestowed on him. Possibly the country-wide recognition of his high qualities and achievements can best be shown by his selection in 1952 to serve as President of the American College of Physicians. For many years up to the present Dr. Pincoffs has been Editor of the Annals of Internal Medicine. With the advent of World War II he again entered the armed forces and served as Colonel, Medical Corps, U. S. Army, from 1942–1946. During the later days of the war he was Chief Consultant, USAFFE. It was in 1942 that Dr. Pincoffs relinquished his position as Head of the Medical Department at Mercy and these duties were taken over by the writer.

The latter, together with Dr. J. Sheldon Eastland, now Associate Professor of Medicine, spent many years of student bed-side teaching on the medical wards at Mercy. In more recent times one of the additions to our teaching staff has been Dr. Hugh J. L. Marriott, who during his stay with us and at his relatively tender years is the author of "Medical Milestones," published in 1952 and "Practical Electrocardiography" in 1954. Both books have been well received and the latter is going into its 2nd edition in 1957.

It might be added here that in truth our Medical Department has in recent years not been without a few "medical world firsts." In 1940 we had on the medical wards two cases of severe hemolytic blood transfusion reactions which on study were caused by no agglutinogen yet described. Working with the noted blood group serologist, Dr. Alexander S. Wiener of New York, the latter found the agglutinogen was identical with a factor discovered in the laboratory by Landsteiner and himself some years before and which had been thought to have no clinical significance. It was thus in 1940 that our cases at Mercy brought about the first report in medical literature on the clinical implications of the Rh factor. Within a year Dr. P. Levine described the importance of this factor in the causation of most cases of "Rh babies."

For several years prior to 1943 anticoagulants were studied and used at Mercy. Our biochemist, Charles E. Brambel, Ph.D., was the first to secure Dicumarol and offer its use to clinicians here. Its value in various surgical conditions (post-operative prophylaxis, embolism, thrombosis, etc.) was confirmed. Because of the rather high incidence of thrombo-embolic complications found in Acute Coronary Thrombosis we began Dicumarol administration on such patients in March, 1943. It was, then, in February, 1946 that the first widely circulated report on the use of Dicumarol in Coronary Thrombosis (Journal of A.M.A.) came from the Medical Department of Mercy. Our claims of appreciable reduction in morbidity and mortality, as well as similar claims of several other initial investigators, was corroborated in 1948 by a country-wide survey. Such anticoagulant drugs are now used in Coronary Thrombosis in many clinics throughout the world. Incidentally, the Mercy Hospital Anticoagulant Clinic is by far the largest in this area and its Out-Patient Department is one of the largest in the country.

### The Future

It can be stated simply that the future of the Medical Department, and indeed of every department at Mercy, can be bright and even brilliant with the resolution of but one difficulty. Situated in almost the geometric center of Baltimore, Mercy Hospital has given medical aid not only to those nearby but patients from all outlying sections of the city converge in increasing numbers to this institution presided over by the Sisters of Mercy. The friendly atmosphere of Mercy, engendered by their dedicated, kindly and skillful ministrations, has long been a tradition.

With ever-increasing population and clamor for treatment here the lack of accommodations in our present buildings is reaching an almost tragic crisis. Facilities for all-important scientific studies and research are now carried on in woefully inadequate quarters.

It is then with deep thankfulness and joy that we now find our difficulties about to be resolved with the announcement of the great new Mercy Hospital, which will rise on our present site. Funds for the erection of this huge edifice must, of course, be acquired. The Sisters of Mercy Hospital has, down the years, had the role of "givers" to Baltimore, never "receivers." Now that they must ask help for the first time to build in downtown Baltimore this veritable Monument for healing the sick, we believe the citizenry of this 'monumental city' will, with an acute sense of gratitude, respond nobly.

*1127 North Calvert Street*
*Baltimore 2, Maryland*

# SURGERY

DANIEL J. PESSAGNO, M.D.*

This is a feeble attempt, at best, to set down in chronological order the history of the Department of Surgery at Mercy Hospital as an integral part of The College of Physicians and Surgeons since its inception in 1872, and later as part of the University of Maryland Medical School.

In the years preceding the birth of the College of Physicians and Surgeons, a group of illustrious doctors were teaching medicine by private courses at The College of Medicine of Maryland, later known as The University of Maryland and The Washington Medical College. They were in the main, temperamental and sensitive of their privileges. Contention and discord was their lot, and quarrels were frequent. It was inevitable that some would break away; and in 1867, with the aid from the city and state, Doctors Edward Warren, H. L. Byrd and Thomas L. Bond instituted The Washington University School of Medicine at the northeast corner of Calvert and Saratoga Streets. Later they moved to an old public school on the northwest corner and joined with The City Hospital adjacent to the City Springs. In 1872 when the old "bugaboo," discord, again arose, Doctors Warren, Thomas Opie, John Lynch, Erich and others incorporated the College of Physicians and Surgeons and brought in a group of men as a nucleus of their staff. Among them were Doctors Latimer, Brown, and Aaron Friedenwald, who in turn had a hand in developing some illustrious surgeons of our institution, such as Doctors John W. Chambers, John Blake, and, later, William Requardt.

The first Professor of Surgery was Edward Warren, who served but two years. He graduated from The University of Virginia and later from The Jefferson Medical College. He is described as a man of unusual ability. He was physically at-

* Chief of Surgery, Mercy Hospital.

tractive, mentally keen, and possessed a dash and manner that brought him to high places in an adventurous life. In his youth he went to Paris to further his medical education and enjoyed the association of such men as Trousseau, Velpeau, Nelation and Charcot. In 1860 he succeeded to the chair of Therapeutics and Materia Medica at the University of Maryland upon the retirement of Doctor Charles Frick.

At the outbreak of the Civil War, Dr. Warren joined the Confederate Army, where he served with distinction, rising to the rank of Brigadier General. When the war ended he returned to Maryland, but was unsuccessful in his attempts to regain his position in the University. It was a little later, as stated above, that he and others launched The Washington University School of Medicine.

About the time of his appointment to the Chair of Surgery, Doctor Warren was called to testify as an expert witness for a Mrs. Wharton, who was accused of poisoning General Ketchum with tartar emetic. His testimony that the General died of Cerebral Spinal Meningitis obtained her acquittal; and it was at the trial that he made the retort to the Prosecuting Attorney which has become famous. To the statement by the attorney that "You doctors bury your mistakes six feet under the ground," Warren replied, "You lawyers hang yours six feet above the ground." However, the trial did him no good, and as a result he "lost face," so to speak.

He went to Egypt as Chief Surgeon for the Egyptian Army, where he developed Trachoma. He went to Paris for treatment and renewed the acquaintances he had made in his youth. When he was advised not to return to Egypt, he settled in Paris, where he built a prosperous practice, receiving honors from various sources. He died in 1893.

He was succeeded as Head of Surgery by Doctor T. S. Latimer, who served but two years. He later became Professor of Physiology and Diseases of Children (the term Pediatrics was not in use in those days), and still later became Professor of Medicine.

In 1877 The College of Physicians and Surgeons took over the Washington University and obtained possession of the building at Calvert and Saratoga Streets and control of the City Hospital. Doctor Latimer was succeeded by Doctor Oscar J. Coskery, with the title of Professor and Chief of Surgery and continued in the chair until 1886. Doctor Coskery was succeeded by Doctor Charles F. Bevan, who previously held the Chair of Anatomy. Dr. Bevan's new title was Professor of the Principles and Practice of Surgery and Genito-Urinary Surgery. Some of our contemporaries still speak with awe of this illustrious surgeon and lecturer. He served until 1906; and it was during his tenure of office, in 1890 to be exact, that the new City Hospital was completed by the Sisters of Mercy on the City Springs lot adjoining The College of Physicians and Surgeons.

Doctor Bevan was succeeded as Professor of Surgery by Doctor John W. Chambers. He was the last of this group who did General Practice along with his surgery; and as busy as he was, no one could dissuade him from his course. Associated with him were Doctors A. C. Harrison; C. F. Blake, who later became Professor of Proctology; and Alexius McGlannan.

Doctor Chambers started out in the morning on his calls and visited patients with pneumonia, typhoid fever, etc. He arranged to have his associates meet him at the homes of other patients. Between calls, he would remove a kidney or perform a hysterectomy or some other surgery. Doctor Chambers died unexpectedly in 1917.

It should be recorded here, that in 1915 the University of Maryland Medical joined with The College of Physicians and Surgeons and, whereas dissension and bickering were prevalent previously, the combined faculties worked happily in harmony and with interlocking personnel.

Following the death of Doctor Chambers, Doctor A. C. Harrison was made Professor of Surgery of the combined schools. The Surgical

Service of Mercy Hospital was divided between Doctor Harrison and Doctor Alexius McGlannan, each having three days a week and Doctor Walter D. Wise was the Chief on the remaining day.

In 1899 Doctor Isaac Trimble became Professor of Anatomy and he brought Doctor Harrison to Mercy Hospital with him and appointed him demonstrator in Anatomy and Associate Professor of Surgery. Doctor Harrison was the first General Surgeon at Mercy Hospital with a full appreciation of aseptic surgery, and it was he who introduced its principles to the Surgical Staff. He was a great teacher and surgeon.

Upon his death in 1926 The University of Maryland and The College of Physicians and Surgeons, along with the Hospital, closed ranks, and Doctor Alexius McGlannan was made the Head of the Department and soon thereafter was made a full Professor in the School.

Doctor McGlannan lived a full medical life. A graduate in Pharmacy, and for six years a close associate of Doctor Bloodgood in Pathology, he was an indefatigable worker and a prolific writer and many honors came to him during his career. Unfortunately, he suffered a stroke in 1933 and retired from active practice, but continued his writing until his death in 1940. His influence and example shall live with us.

Following the retirement in 1935 of Doctor McGlannan, Doctor Wise was made Head of the Department of Surgery at Mercy Hospital and Professor of Surgery at The University of Maryland School of Medicine. He was a protégé of Doctor Harrison and learned his lessons well.

At the outbreak of the Second World War, Doctor Wise entered the service and became Consultant Surgeon for the Third Army Service Command from 1943–1945, work for which he was awarded the Army's Legion of Merit. Dr. Wise remained on active military duty for four years, and during his absence from Mercy as Chief of Surgery, Doctor Elliott Hutchins served as Chief Surgeon with the rank of Professor of Surgery in The University of Maryland.

Doctor Wise retired as Head of the Department of Surgery in 1955. It would be better to say that he stepped aside as he is still actively engaged in the Practice of Surgery, and we all look to him for advice and counsel.

The writer of these rambling notes is the present Head of the Department of Surgery. This is meant to be a history of the Department of Surgery at Mercy Hospital and therefore no attempt has been made to fully list the many accomplishments of the men who have preceded me.

I would say that they were an illustrious and influential group, approachable and friendly, and they made history in Medicine. I assure you that I feel woefully inadequate when I reflect upon their lives and accomplishments.

*Medical Arts Building*
*Baltimore 1, Maryland*

# OUT-PATIENT CLINICS

S. EDWIN MULLER, M.D.

In 1874, the State of Maryland transferred an old, abandoned public school on the northwest corner of Calvert and Saratoga Streets to the College of Physicians and Surgeons for the establishment of a hospital. The out-patient clinic and the pharmacy were opened on the basement floor.

In the same year, the school opened on Lombard Street the first Lying-In Hospital and Clinics in the state. This clinic was moved

to Calvert Street in the year of the Baltimore Fire.

In 1920, a Social Service Department was conducted in connection with the out-patient clinics under the auspices of the National Catholic War Council. In 1922, the Social Service Department became an integral part of the Mercy Hospital.

From 1922 to 1937, various clinics, including Diabetic, Cardiac, Bronchoscopic and Neuropsychiatric were opened. In 1937, the entire out-patient department was re-organized and the physical therapy clinic added. In 1938, the Prenatal Clinic was revitalized.

In 1950, the Medical Care Clinic for the care of the indigent was opened. Since then, the Thoracic Surgery, Hypertensive and Arthritis clinics have been added.

In the fiscal year of 1956, 29,358 patient visits were made to the clinics. Approximately 45 per cent of this number were seen under the medically indigent program. This group, except for medical aid, does not receive public assistance. About 33 per cent were part-pay patients and 22 per cent of visits were made by indigent patients under the Medical Care Program. This group does receive public assistance. A total of 67 per cent of all the visits made receive care at no cost to the patient. Approximately 30 per cent of visits were made by colored patients.

In the Mercy Hospital Clinics, as in other similar institutions, the rising costs of drugs is of great concern to those in charge of the administration. This is especially true when the expense is borne by public funds. Efforts have been made to improve this fault by means of a hospital formulary. This problem has not been solved satisfactorily.

The teaching of medical students and house officers has continued through the years in some of the Mercy Hospital Clinics. This, is, of course, a very important function.

From the history, it would seem that, in the beginning, the out-patient department was an important part of the Mercy Hospital. This continues to be true. A prerequisite of a teaching hospital is an excellent out-patient clinic. For the past eight years this department has been under the direction of Sister Mary Anita, R.S.M.

*2 West Read Street*
*Baltimore 1, Maryland*

# OBSTETRICS AND GYNECOLOGY

FRANK K. MORRIS, M.D.*

Probably few people are aware that Mercy Hospital's Obstetrical and Gynecological Department traces its origin back to the first Lying-in Hospital founded south of the Mason-Dixon Line. Yet there is an unbroken series of direct links extending from today's bustling pace back to 1874 when Dr. Frederick Erich and Dr. Thomas Opie, two of the giants of their times, established the Maryland Lying-in Hospital on Lombard Street between Sharp and Hanover Streets.

Established under the auspices of the College of Physicians, this institution claimed the leading medical men of the latter part of the nineteenth century as its staff members. When the Baltimore Fire destroyed the Lombard Street buildings, Maryland's patients were removed to the safety of the sixth floor of Mercy Hospital, then known as City Hospital.

In addition to the part he played in connection with the establishment of the Maryland Lying-In

* Chief of Gynecology at Mercy Hospital, Director of the Department of Obstetrics and Gynecology at South Baltimore General Hospital and Assistant Professor of Gynecology at the University of Maryland Medical School.

Hospital, Dr. Erich is also linked with Mercy Hospital by the fact that he was the Founder of the Maryland Woman's Hospital which occupied a residence which has since become the present Mercy Hospital Annex Building.

Dr. Erich and Dr. Opie were men of great and diverse talents. A graduate of the University of Maryland in 1861, Dr. Erich served as Gynecologist at the Baltimore Special Dispensary in 1868, as President of the Medical and Surgical Society, as Professor of Chemistry at the College of Physicians and Surgeons in 1874. He was also Editor of the Baltimore Physician and Surgeon, 1873–76. In addition, he was Surgeon in Charge of the Maryland Woman's Hospital from 1877–86. He also invented a self-retaining vaginal speculum. Dr. Erich died on December 7, 1886.

Dr. Erich's successor was Dr. Thomas Opie, Professor of Gynecology and Dean of the Faculty of the College of Physicians and Surgeons until his retirement in 1903.

Upon Dr. Opie's retirement, Dr. William Sisson Gardner, a former Lecturer on Obstetrics and Demonstrator of Chemistry at the College of Physicians and Surgeons, succeeded him in his professorial duties and, in addition, became Chief of Gynecology at Mercy Hospital. Dr. Gardner continued in these capacities until 1915 when the College and the University of Maryland Medical School amalgamated. Thereupon, Dr. Gardner became Professor of Gynecology at Maryland Medical School and Chief of Gynecology at the University Hospital. He continued in these posts until 1934.

Dr. Abraham Samuels, Clinical Professor of Gynecology at the University of Maryland Medical School, succeeded Dr. Gardner as Chief of Gynecology at Mercy. Before he specialized in gynecology, Dr. Samuels had taught chemistry and later genito-urinary surgery at the College of Physicians and Surgeons. Before his death in 1943, Dr. Samuels also served as Chief of Gynecology and Pathologist at the Sinai Hospital from 1919.

The next Chief of Gynecology at Mercy Hospital was Dr. Thomas K. Galvin, who also was Clinical Professor of Gynecology at the University of Maryland and Chief of Gynecology at St. Joseph's Hospital. Dr. Galvin served for a decade, until his death in 1953.

Until 1951, the medical students at the University of Maryland Medical School were taught Gynecology at Mercy. This, of course, was an additional link to the old College of Physicians and Surgeons and its early activities. This practice was discontinued in 1951 in favor of teaching at University Hospital.

At the turn of the century, Dr. George W. Dobbin, Professor of Obstetrics at the College of Physicians and Surgeons, was also Chief of Obstetrics at Mercy. Dr. Charles Emil Brack, Associate Professor of Obstetrics, and Dr. Glenn M. Litsinger, Demonstrator of Obstetrics, both taught at Mercy until 1915, when the College of Physicians and Surgeons merged with the University of Maryland Medical School.

When Dr. Brack died, he was succeeded by Dr. E. P. Smith as Chief of Obstetrics at Mercy. Upon Dr. Smith's retirement of 1950, Dr. John Erwin, the present Chief, succeeded him.

Of particular benefit to the medical community has been the graduate program in gynecology and obstetrics established in 1938 by Dr. Samuels and Dr. Smith. The program consists of three years of training after one year of interneship. It qualifies Mercy's residents and allows them to take the examinations of the American Board of Obstetrics and Gynecology. When they pass their examinations, they are listed as specialists. Nearly all past Mercy residents are now Diplomates of the American Board. Most of Mercy's Chiefs have received their training at the College of Physicians and Surgeons and the Mercy graduate program. The number of house officers at Mercy on the Obstetrics and Gynecology service, which was two in 1938, is now seven.

A study of available statistics demonstrates how vast has been the growth of patients treated

in Mercy's Gynecological and Obstetrical Departments. A summary of In-Patients treated in Obstetrics over ten year periods shows the following averages:

1910–1919— 355 per year
1920–1929— 398 per year
1930–1939— 418 per year
1940–1949—1351 per year
1950–1956—2674 per year

Prenatal clinic visits have been handled on an average of a little in excess of 2300 per year. Gynecology service figures reveal the following averages over ten year periods:

| | *In-Patients Per Year* | *Out-Patients Per Year* |
|---|---|---|
| 1910–1919 | 370 | 1603 |
| 1920–1929 | 570 | 1146 |
| 1930–1939 | 549 | 1106 |
| 1940–1949 | 878 | 1051 |
| 1950–1956 | 933 | 1731 |

An examination of Mercy's future plans for the New Delivery Suite and Maternity Units demonstrates that in the not too distant future the record delivery of 2700 babies at Mercy in 1956 will look small in comparison with the 3600 deliveries which can be expected in the new quarters. This represents a 33 per cent increase over our best efforts.

The plans for the new units show a special elevator for the Maternity Delivery floors and the planning indicates that the new quarters will provide a maximum of efficiency.

In the face of spacious and up-to-date facilities, it is interesting to note that even as late as 20 years ago, 35 per cent of all babies were born at home. Population growth and increased hospital facilities have reduced this percentage to 2.8 per cent in Baltimore. In 1920 only 352 maternity cases were treated at Mercy; in 1956, that number was 2700. Subsequently, there has been a marked decrease in both Maternal and Foetal Mortality and Morbidity.

Mercy's Gynecological and Obstetrical Departments will, no doubt, be entering into a new era upon the completion of the new quarters. It owes much to the men who have staffed it over the decades. It owes much to the old College of Physicians and Surgeons from which it drew so many of its staff members. Because of that connection, Mercy's roots will remain strongly planted in the history of that which has been best in medical treatment in the metropolitan Baltimore area.

*11 East Chase Street*
*Baltimore 2, Maryland*

# OTOLARYNGOLOGY

THEODORE A. SCHWARTZ, M.D.*

Each year, more than 3,000 out-patient visits are made to the small and inadequate but well-equipped and ably staffed Ear, Nose and Throat Clinic of the Mercy Hospital. Each year, more than 1,250 surgical otolaryngological procedures are performed, representing approximately 20 per cent of the total number of operations performed in the hospital. Two Residents, one Interne, thirteen active Staff members and equipment worth more than $10,000 is quite a far cry from those early days when in 1874 the Faculty of the Washington University decided to confide the care of their Hospital to the Sisters of Mercy.

At that time, the specialty of Eye, Ear, Nose and Throat had been elevated just about to the

* Head of the Department of Otolaryngology, Mercy Hospital, Assistant Professor of Otolaryngology, University of Maryland Medical School, and President of the Baltimore Nose and Throat Society.

point where its "quackery" label had disappeared. Prior to 1800, many had held that Eye, Ear, Nose and Throat was practiced only by quacks and even Abernathy, when asked to serve as Honorary Chairman of the London Eye and Ear Infirmary in the middle of the century, said he could see no good that could arise for the public—"I candidly tell you I consider it quackery."

The appointment of Dr. George H. Thomas, a pioneer in the study of Diseases of the Nose, Throat and Chest, as first Chief of the Department of Otolaryngology was met with wide acclaim both locally and nationally. For many years, the Department of Eye and Ear was administered as a single unit and that of Nose, Throat and Chest as a separate specialty, both under the Department of Surgery. Following the death of Dr. Thomas, the Ear, Nose and Throat Departments were united and headed by Dr. Frank O. Sanger, and later by Drs. George W. Mitchell and Waitman F. Zinn.

Dr. Sanger's technique of tonsillectomy and adenoidectomy, now obsolete in light of our present aseptic and modern methods, is still a popular conversational and teaching subject among the younger men. The patient was seated in a straight-back chair and the tonsillectomy and adenoidectomy were performed by dissection between periods of deep anesthesia, induced by the anesthetist holding a paper cone partially filled with cotton and saturated with ether over the nose and mouth.

It was Dr. Zinn who, after practicing ten years in Baltimore, became interested in the work being done by Dr. Chevalier Jackson on the removal of foreign bodies from the lungs and esophagus. He studied with Dr. Jackson in Philadelphia and returned in 1920 to start the Bronchoscopic Clinic in a large room on the fifth floor of the Mercy Hospital. At that time it was the only clinic of its kind in Baltimore and the largest south of the Jackson Clinic in Philadelphia.

The years I spent, together with Dr. Fayne A. Kayser, in association with Dr. Zinn, were priceless ones in experience gained, and it was during this time that many improvements in old technique and various new techniques in surgery of the ear, nose and throat were instituted and perfected.

Following Dr. Zinn's resignation as Head of the Department in 1953, the Bronchoscopic Clinic was moved to its present location adjacent to the Ear, Nose and Throat Out-patient Clinic and X-ray Department. All new and modern equipment was purchased at that time. A "T & A" ward for children was opened with ten beds available each day, all under the constant supervision of specially trained nursing personnel. In 1953, a postgraduate training program was established, which, after a survey, was approved by the Committee on Accreditation of the American Medical Association in conjunction with the American Board of Otolaryngology for a three year residency program.

During the first year the resident deals with in-patients in the hospital and becomes familiar with pre- and post-operative care. He is then transferred to the Dispensary, where he is instructed in the diagnosis and therapeutic management of patients who visit the out-patient clinic. He is then able to assume increasing responsibilities in the operating room. Basic sciences are taught in correlation with the material. Anatomy of the head and neck, embryology, pathology, radiology, operative surgery of the temporal bone, endoscopy, functional hearing tests, applied physiology and pharmacology, allergy, speech pathology and plastic surgery are all covered by men specializing in each subject.

At the present time each junior student at the University of Maryland Medical School receives in the Mercy Hospital out-patient clinic nine hours of demonstrations and lectures which teach the technique of examination and cover the entire field of otolaryngology as it pertains to the general practice of medicine. Interest in the

field of otolaryngology is stimulated in these students and those exhibiting a special desire toward this field are encouraged by personal supervision. It is gratifying to observe that even after these few hours, the students show considerable aptitude in the technique of examination of the patient and they carry away with them an appreciation and understanding of the types of patients they are likely to see in a general medical practice.

The new Mercy Hospital soon to be built will certainly contribute to the further progress of otolaryngology in this country. Plans have been formulated, subject to architectural and administrative approval, to coordinate the various sections of the specialty in one area of the hospital—audiology, out-patient department, private out-patient clinic, broncho-esophagology, operating rooms, research laboratories, conference rooms, library and administrative offices. This physical arrangement, together with the increasing ever-present staff cooperation and interest, will beyond any doubt result in a nationally recognized department.

*834 Park Avenue*
*Baltimore 1, Maryland*

# PEDIATRICS

EDGAR B. FRIEDENWALD, M.D.*

Pediatrics as a specialized branch of medicine had no real existence before the middle of the nineteenth century, being taught at the medical schools in combination with other branches, especially with the chairs of Gynecology, and Obstetrics but also associated with venereal diseases and dermatology.

Doctor Thomas Latimer held the title of Professor of Physiology and Diseases of Children at The College of Physicians and Surgeons from 1876 to 1883, he retained his interest in Diseases of Children and acquired a well deserved reputation as an expert in Diseases of Children. He was one of the founders of The American Pediatric Society and served on its first Board of Governors in 1888. He also contributed articles on Pediatrics to "Keating's Cyclopedia of Diseases of Children," and Starr's "Text-Book of Diseases of Children, by American Authors."

Doctor Latimer also held the chair of Professor of Principles and Practice of Medicine at The College of Physicians and Surgeons from 1883 to his demise, as well as Chief of Medicine at The Baltimore City Hospital (now Mercy Hospital) 1909. He was Professor of Diseases of Children at The Baltimore Polyclinic in 1884.

Until the erection of the original building of Mercy Hospital in 1889, there was no separate provision for children at the hospital. Only after the opening of the northern addition in 1909, was there a Childrens Ward. This was on the third floor directly beneath the Chapel.

The Childrens Ward was moved to its present location in the College building in 1934 and the milk kitchen was removed from adjoining the Childrens Ward in 1942, occupying the space formerly occupied by the Diet Kitchen. The Infant Station in the Obstetrical Department was improved in 1942. Until the Great Baltimore Fire in 1904, The College of Physicians and Surgeons, conducted The Maryland Lying-In Hospital, on Lombard Street, between Sharp and Hanover Streets. This was the first Lying-In hospital in this country, south of the Mason-Dixon Line. Because of the danger during the Baltimore Fire, the patients were removed to the Mercy Hospi-

* Consultant in Pediatrics at Mercy Hospital, where he was formerly Chief of Pediatrics from 1935 to 1950. He is also Professor Emeritus of Clinical Pediatrics at the University of Maryland School of Medicine.

tal. The sixth floor of Mercy became the Obstetrical Department, which was removed to the second floor when the northern addition was opened in 1909.

Dr. Frank C. Bressler, who had graduated from The College of Physicians and Surgeons in 1885, and who had been House Officer at the City Hospital, from 1885 to 1886, became Lecturer on Diseases of Children and later Clinical Professor of Diseases of Children, under Doctor Latimer.

Dr. John Ruhräh, who graduated from The College of Physicians and Surgeons in 1894, was Assistant Resident Physician, City Hospital (now Mercy Hospital) 1894–95, became Resident Physician, 1895–97. He studied in various pediatric clinics of Europe from 1898 to 1901. He was retained as Associate Professor of Diseases of Children at The College of Physicians and Surgeons in 1902. He became Professor of Pediatrics in 1909, upon the death of Dr. Latimer, who had held the Chair of Principles and Practice of Medicine and Diseases of Children from 1883 to 1909.

Upon the merger of The College of Physicians and Surgeons with The Medical School of The University of Maryland in 1915, he continued as Professor of the combined schools until his demise in 1935.

Dr. Edgar B. Friedenwald, upon his return from Germany, where he had engaged in the study of Pediatrics, in 1910 reorganized the Childrens' Dispensary and taught Pediatrics with various titles at The College of Physicians and Surgeons and later at the merged schools as Professor of Clinical Pediatrics until his retirement in 1950. Dr. Frederick B. Smith, who had been associated with Dr. Ruhräh for quite a number of years and who also was Associate Pediatrician at Mercy Hospital, succeeded to the position as Chief of Pediatrics at Mercy Hospital in 1950. The Pediatric Department received approval from The American Academy of Pediatrics in 1947.

In 1955 Mercy Hospital entered into a joint residency training program with the University of Maryland. This same year, the pediatric residency program was approved for two year training by the American Medical Association.

*1701 Eutaw Place*
*Baltimore 17, Maryland*

# SCHOOL OF NURSING

SISTER MARY JOSEPH, R.S.M.*

The Mercy Hospital School of Nursing was organized in 1898 by Sister Mary Imelda Burford. It was incorporated under the laws of the State of Maryland, December 23, 1901, under the title The Baltimore City Hospital Training School for Nurses. It is worthy of note that this is one of the few schools of nursing of that period that was separately incorporated.

On December 27, 1898, the school admitted its first student, Miss Sarah Ward of Capon Springs, Virginia. Miss Ward was soon followed by three other young ladies; six Sisters joined them. Miss Catherine McNamara, a graduate of St. Joseph's Hospital, Chicago, "quietly took charge of the school."

Some of the professors who lectured, taught, and assisted in every possible way were: Doctors Thomas Opie, Nathan R. Smith, George Preston, William F. Lockwood, Samuel Fort, C. Hampton Jones, John W. Chambers, Aaron and Harry Friedenwald.

The first graduation was held on December 27, 1901 in the surgical amphitheater of the College

* Director of Nursing at Mercy Hospital.

of Physicians and Surgeons. Doctor Thomas Opie, Dean of the College presided, presented the diplomas, and spoke. Six Sisters and the Misses Sarah Ward, Ann Dolan, Clare Maguire, and Lillian Oligrath received diplomas.

In February, 1902, Sister Mary Gonzaga Martin, a graduate of 1901, became superintendent of nurses. "She was substantially aided by the professors of the College, who were untiring in their endeavor to make the school second to none in the country."

Registration of nurses began in Maryland when the school was only a few years old. The first Sisters were registered under the waiver as were graduates of other acceptable schools.

In 1906, "the successful conclusion of the registration of the school with the Board of Regents of New York was announced." Today when registration to practice nursing is secured by passing the National League Tests, and when National Accreditation has overshadowed recognition by other similar agencies, registration with the Board of Regents of New York has lost most of its significance. For a quarter of a century, it was a coveted honor enjoyed by few Maryland schools; neither was it an empty honor. It opened the way for Mercy graduates to practice in New York without further examination or litigation. The conditions were exacting and to maintain the level of excellence often demanded the greatest effort of which the school was capable. Because the challenge is stimulating and healthy, Mercy has cherished and continued the connection unbroken since 1906.

The present nurses' residence on Calvert and Pleasant Streets was occupied in 1919 and contains classrooms, nutrition and nursing arts laboratories and a library. When it was opened, it was thought to be large and elaborate. Today it is as crowded and inadequate as its forerunners had each in turn come to be.

Since the founding of the Nursing School, 1,573 students have graduated. The current enrollment includes 60 freshmen, 44 juniors, and 29 seniors.

Mercy's School is accredited by The Accrediting Service of the National League for Nursing and the Maryland State Board of Examiners of Nurses. The School also holds membership in the Conference of Catholic Schools of Nursing in the United States and Canada.

One hundred seventeen lay graduates of the Nursing School are employed at the Hospital. This included ninety-one full time and twenty-six part time employees.

*Mercy Hospital*
*Calvert and Saratoga Streets*
*Baltimore 2, Maryland*

# PATHOLOGY

C. GARDNER WARNER, M.D.*

The establishment and growth of Pathology at Mercy Hospital is intimately related to the general evolutionary development of the Institution.

The founder and father of this laboratory branch of medicine was Dr. Nathaniel Keirle. He was Baltimore born, of German parentage, and graduated from the University of Maryland in 1859. He had an investigative and scientific mind far beyond his day. He was the first Professor of Pathology and medical jurisprudence at the time of the absorption of the Washington Medical College by the newly organized College of Physicians and Surgeons. He had an intimate association with Dr. William Welch when he came to Baltimore in the late 80's.

Early in the 1890's, a rabies epidemic developed in Baltimore City and vicinity. This was Dr. Keirle's absorbing interest. He established a

* Director of the Pathology Laboratory at Mercy Hospital.

Pasteur Institute at the College of Physicians and Surgeons and carried on meticulous and extensive investigative experiments on rabbits in developing a satisfactory virus. This Keirle's Rabies Virus was widely used on a nationwide basis. This clinic operated from 1896 to 1915 in the basement of the College Building at Saratoga and Calvert Streets.

Under Dr. Keirle, three men were trained and developed who have left their imprint in Pathology and laboratory medicine in Baltimore; Dr. Standish McCleary, Dr. William Royal Stokes, and Dr. Caleb W. G. Rohrer.

Dr. McCleary succeeded Dr. Keirle as professor at the College of Physicians and Surgeons and maintained this title after the merger with the University of Maryland in 1915 until his death in 1934. With the establishment of a postmortem physician to supplement the coroner system in Baltimore City, Dr. McCleary became its head. He continued as Pathologist at Mercy Hospital until 1930, when Dr. Walter C. Merkel took over his duties.

Dr. Stokes and Dr. Rohrer both became associated with the City Health Department. Dr. Stokes met a premature and untimely death in experimental psittacosis during a mild epidemic in 1928. Dr. Rohrer lived for many years in semi-retirement. He conducted research on cancer in a laboratory in his own home for many years.

With the gradual development of clinical medicine, the needs and work of the laboratory facility have greatly increased. In 1914 Dr. Henry T. Collenberg, a graduate of Hopkins, became associated with the Clinical Laboratory at Mercy and began to develop a school for training technicians. He was soon joined by Dr. John Houck, a hematologist from Hopkins, and later Dr. Raymond Peters directed his interest toward this branch. Dr. Emil Schmidt became associated as the chemist.

From humble beginnings in several small rooms, this department has developed and expanded to now occupy the entire fifth floor of the old College Building. From one technician and a few thousand tests a year, it has grown to a certified training school with fifteen full time technicians and teachers, in addition to the students. The work load is now over a half million tests a year. This was the first registered training school for technicians in Baltimore. It is affiliated with St. Agnes College, Mt. Washington, for the necessary college credit courses.

In 1935, Dr. Charles Brambel came to Mercy as the chemist when Dr. Emil Schmidt assumed full time duties as a professor at the University of Maryland. In collaboration with Dr. Peters, Dr. Brambel developed an anticoagulant clinic and conducted considerable experimentation in substances that have an anticoagulative effect on blood.

There has been a periodic shifting of parts of the laboratory facility with the growth of the clinical and tissue laboratories. The tissue laboratory was moved to the third floor on the Saratoga Street side with expansion of the Dicumarol Clinic. With no further room for expansion, the need of a new building is constantly emphasized.

In 1952, Mercy Hospital took on a full time Pathologist, Dr. C. G. Warner, University of Maryland and City Hospital trained. This was to fortify the postgraduate educational program of the hospital, maintain and improve the grade of surgical and medical care by undergirding and extending the educational background of all those concerned with patient care, interns, residents, nurses, and technicians.

This service acts as consultant to the Hospital specialists in tissue, cytological, and autopsy examinations. An active rapid frozen section diagnosis is offered. The residency training program is fortified in all departments by clinics, seminars and conferences. The department is also affiliated with the University of Maryland Medical School for student teaching. It is certified for three years of residency training in Pathologic Anatomy.

*Mercy Hospital*
*Calvert and Saratoga Streets*
*Baltimore 2, Maryland*

# MEDICAL SOCIAL SERVICE

SISTER MARY SCHOLASTICA, R.S.M.*

In January, 1920, the Social Service Department of Mercy Hospital had its beginning under the auspices of the National Catholic War Council. Two years later, February, 1922, Mercy Hospital found this department such a valuable asset that the Administration accepted complete financial responsibility. Since that time Social Service has been an integral part of Mercy's service to its patients.

During the intervening years, Social Service has changed its function to adapt to the changing concepts and needs in Medical Care. This department now works with over a thousand patients and their families each year. The problems dealt with center principally around social adjustment to illness. Working with difficulties which may interfere with the patient making the best possible use of medical care; preventing problems by anticipating obstacles that may occur; assisting individuals in their adaptations to permanent ill health are some of the activities in which the Medical Social Workers engage. Rehabilitation, both educational and vocational, is stressed in most of the contacts with individual patients.

This department at Mercy also works very closely with many agencies in the Baltimore Community. The Staff looks forward to a new hospital in which there will be more space for additional social workers. This will make it possible to extend services to greater numbers of patients in order to prevent social problems from occurring by reaching more patients and their families earlier in illness.

* Director of the Social Service Department of Mercy Hospital.

*Mercy Hospital*
*Calvert and Saratoga Streets*
*Baltimore 2, Maryland*

# CLINICAL LABORATORY

SISTER PAULA MARIE, R.S.M.*

The profession of Medical Technology is comparatively a newcomer to the field of medicine. In the early days of laboratory work, the procedures were simple and not so tremendous in number. Any tests that were performed, such as urine examinations and blood counts, were all done by the physician or pathologist. As scientific investigation advanced and new vistas were opened to medicine and the treatment of human ills, the doctors and pathologists found it necessary to train assistants to help them perform the simpler tests. This initial expansion could be dated from the First World War and marks the birth of a new profession in the medical field.

These first assistants were persons with a very meager education who became apprentices in medical laboratories or doctors' offices. As the technics became more complicated, and as these persons were not sufficiently educated to cope with the mechanics of laboratory testing, many problems arose. In 1928, the American Society of Clinical Pathologists, realizing that the rapidly developing horizon of the clinical laboratory would necessitate some type of standardization in the training of these labora-

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tory assistants, established the Registry of Medical Technologists.

The Registry is the only recognized qualifying body of Medical Technologists. It has elevated the status of the medical laboratory assistant to a high professional level by gradually raising the educational requirements and broadening the training and hence improving the type of work done by the clinical laboratory.

Mercy's Laboratory and School of Medical Technology has kept pace with the advancing trends in this field. In March, 1918, Mercy opened the first organized clinical laboratory in two small rooms on the fourth floor, where we now have Rooms 426 and 427. Dr. H. T. Collenberg was in charge as Director, with one assistant. In 1920, Sister Mary Joan was appointed to take charge of the Laboratory. The work increased, more space was needed, and more technicians were added until 1927, when the laboratory was moved to its present quarters.

In 1933, through the efforts of Dr. Collenberg and Sister Mary Joan, the school was approved for training student Medical Technologists. At present the school is affiliated with Mount Saint Agnes College, and all students receive a degree of Bachelor of Science in Medical Technology and are qualified to take the National Registry examination.

The Clinical Laboratory has grown in educational stature, as well as size. The present location is extremely crowded, due to an increase in equipment and technical staff, which comprises 14 fully certified Medical Technologists, plus secretaries and assistants.

Statistics on the laboratory are available back to 1920, when 10,775 examinations were made. Last year (1956) there were 504,649 examinations. This total breaks down into the following categories: Urology—76,879; Coprology—9,026; Hematology—69,641; Serology—26,576; Blood Bank—63,546; Chemistry—126,950; Venipunctures—64,235; Gastro-Duodenal—1,352; Bacteriology—66,444.

With the vast work load, both by number and variety, it is understandable that the laboratory has outgrown its facilities. Since there is no longer room in the present buildings of the hospital for expansion, the only solution is a new hospital.

*Mercy Hospital*
*Calvert and Saratoga Streets*
*Baltimore 2, Maryland*

# GRADUATE EDUCATION AND RESEARCH

WILLIAM L. GARLICK, M.D.*

Mercy Hospital, since its inception, has been interested primarily in the care of the sick. It has grown from the era in which it was the original College of Physicians and Surgeons of Maryland. In 1915 the college merged with the Medical School of the University of Maryland. From the earliest years of the hospital, students of medicine sought preceptorships and internships in the shifting evolution of graduate training. Belief in the idea of education in the hospital of a medical school graduate in the application of clinical medical practices has been a constant implement of faith which the Sisters of Mercy have pursued in their effort to render better care for the patient.

Graduate education has become a thing of change and progress in the last ten years. It has

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even developed into a specialty field in medical education to the point where one large university gives instruction in the techniques of managing a program of intern and residency training. Many hospitals throughout the country hire physician directors of training programs in order to raise their standards of the care of the sick and also develop better qualified physicians to practice in the community and hospital.

A sub-committee of the intern committee of the Visiting Staff was established in 1953 to explore the field of graduate education and to find a logical application of the many and varied approaches to this problem in a university-affiliated, voluntary, religious hospital, such as is Mercy. The present program was begun at a time when physicians were arguing the pros and cons of creating an extension of medical schools into five-year sessions, of the absurdities of creating basic science departments in non-university hospitals, and of the curiosities of applying biochemistry, physiology and anatomy at the bedside.

The basic design of the present graduate educational program is the constant study of the patient and the application to him of all available medical knowledge and techniques to effect a cure of disease and rehabilitate him into a normal physical individual. The primary requisite which is sought in a medical school graduate is scholarship. The educational program seeks to direct and develop with adequate supervision the young physician into a person of mature judgment.

Graduate education is a two-way sword. It not only instructs the intern or resident, but it also requires the instructing physician to be informed in the development of knowledge related to a specific problem in a patient. The only tenable approach is that the intern or resident is junior in experience only and that his close and constant application to the patient may bring about a better understanding and more satisfactory effect for the patient.

Certain pressures have been brought to bear on programs of graduate education, primarily the accrediting boards and the specialty boards, but there are others: the pay schedules of government hospitals, such as the Veterans Administration; the inadequacy of old buildings to accommodate married house officers; the problem of instruction among hospital employees, such as nurses, orderlies, physicians, all of whom "live-in" at times.

Certainly, the object of graduate education is not the passage of an accrediting board examination. That is a side interest. On the other hand, the necessity of meeting all of the requirements of a residency in an accredited specialty is a necessity in such a program. These effects are accomplished in the following way at Mercy.

The number of basic groups in the hospital is determined by the number of patients in the hospital. In general surgery, for example, there are three divisions or services designated by letters and headed by a senior surgeon. These services are balanced by other visiting staff surgeons, so that the patient load which any house officer on the service carries is about 60 a month, or a maximum daily attendance upon 20 to 30 patients. In order to achieve the broad training which affords the trainee with varied and extensive supervised experience, it is required that he rotate through all services and the specialty services.

A similar procedure is carried out in medicine, and all other divisions, such as obstetrics, gynecology, pediatrics, orthopedics; ear, nose and throat; pathology and dentistry. The free ward services are controlled by the resident of the service under supervision of consultants from the senior staff. Each service is augmented by a weekly conference. In surgery, this takes the form of "grand rounds," where interesting problems are presented and an opportunity is given to discuss problems of physiology, biochemistry, anatomy, and other basic sciences. There are on the staff certain physicians with special interests

in specific fields who are available to emphasize the application of the basic sciences to the fields of medicine and surgery.

In order to achieve an even more liberal training than the hospital can afford, a fund has been established to send promising trainees to other centers of medical education to take advanced courses in fields of special interest or to visit well-known clinics. House officers, for example, have been sent for courses in radioactive isotopes to Oak Ridge, Tennessee; etc. A course in gynecological pathology is coordinated with a city-wide program in another hospital. Being readily available, it has been unnecessary to duplicate it. Likewise, the house officers avail themselves of an opportunity to take a course in surgical anatomy at the University of Maryland.

A weekly calendar is published, giving all of the varied classes, conferences and rounds. Postal cards are mailed to groups of visiting physicians, who normally attend specialty conferences. Because of the large number of services, there is at least one daily conference, and on certain days two conferences, which the house staff is required to attend. It is a peculiarity of house physicians that some can always arrange their patient load in order to be available to attend conferences; others can never arrange their work in such a fashion.

Research has become a part of graduate training. In 1946, the Sisters allowed Dr. Charles Brambel and myself to establish an experimental animal laboratory. In time, it was possible because of the laboratory to obtain a large Army grant and a drug firm grant to carry on experiments in the field of anticoagulants, blood clotting, and cold injury. The laboratory has been made available for any house officer or staff member who has an idea he would like to pursue. Work in the laboratory is required of the resident in thoracic surgery and in ear, nose and throat. Several other services are using these facilities; in surgery, two house officers are studying techniques of blood vessel surgery. Experiments are being carried on in the field of gynecology and in coronary artery surgery. Out of this work has come a cheap blood oxygenator which is receiving clinical trials in open heart surgery. One house officer has developed a portable plastic artificial kidney which shows promise. The cold injury studies were reported to the National Research Foundation and showed a practical application of anticoagulation in the treatment of frostbite. The laboratory is available to anyone on the staff and is supported by the hospital as a necessary function in graduate education.

Available in the hospital is a library, a memorial to one of the former chiefs of staff. It contains many texts and dozens of current journals. In its operation, it is constantly available to both house and visiting staff. A library committee constantly attempts to improve the scope of material available.

There is a monthly journal club which has become one of the more popular house staff functions. Subjects are assigned in various fields and are presented by appropriate house officers who invite senior physicians to evaluate the material and define its proper application. The Journal Club is extremely popular and successful, lunch being served at the meetings.

In the department of medicine, there exists an anticoagulant laboratory, one of three of its size and scope in this country. Two physicians are employed in this laboratory to supervise and study the application of anticoagulant therapy to hospitalized and out-patient service and to research. It has constantly grown since its beginning. It is self sustaining. House officers in medicine are rotated through this service in their training.

The hospital is in the process of establishing a pulmonary function and cardiac catheterization laboratory which will open in March or April. It will employ a physician and several technicians. The resident in thoracic surgery, and also the

resident in medicine, will have training duties in this laboratory. The laboratory is primarily clinical in its concept at the present time.

In the department of electrocardiography, a fellowship has been attached. That department has progressed to the point where Dr. Henry J. Marriott will direct a course in electrocardiography for practicing physicians. The course will be sponsored under the committee of Graduate Education.

One of the constant problems in graduate education is the increasing cost of food, lodging, clothing, and salaries for house officers. The majority of medical school graduates are married and have families. In order to make training possible for many of these men, salaries must be on a scale to permit them to be unburdened by financial problems. Where should this money be obtained? Should it come from the general hospital fund? Should it be charged to the patient, who in the end gains better care from the presence of a constantly enlarging and expanding educational program? And who, in the future, will be given service by very superiorly trained physicians in the community? These are the problems of graduate education id a university-affiliated, voluntary, religious administered hospital.

*700 North Charles Street*
*Baltimore 1, Maryland*

*This concludes the Mercy Hospital Issue of the MARYLAND STATE MEDICAL JOURNAL*

PRE-ADMISSION SERVICE—SPRING GROVE STATE HOSPITAL

At the present time there is a pre-admission service at the Spring Grove State Hospital for patients under the age of 16 and over the age of 65, which is designed to provide consultation service to physicians, families, social agencies and patients. This is primarily limited to these age groups because frequently there is real reason for doubt concerning the advisability of State hospitalization. The Service primarily is to familiarize interested people in the facilities of the hospital, and at the same time to help formulate other plans for the management of these patients, as indicated. It is felt, also, that this contact with the hospital prior to the actual admission of a patient may make hospitalization easier.

Physicians, social agencies and other interested people may feel free to utilize this service by requesting the family to contact Mrs. Hubertine Marshall at Ridgeway 7-4400, Extension 83. Mrs. Marshall may be reached also by letter, directed to Spring Grove State Hospital, Catonsville 28, Maryland.

# Scientific Papers

## TREATMENT OF THE POSTTHROMBOTIC LEG*

ROBERT W. BUXTON, M.D.†

One is hard-pressed indeed, today, to bestir interest and concern and, least of all, enthusiasm for the subject of chronic thrombophlebitis or the postthrombotic syndrome of the lower leg. Such expressions and effort are now reserved for the cardiovascular surgeon who shortly ago may have turned his speculative eye upon the portal venous system, upon the dilations and obstructions of the abdominal and thoracic aorta, and its major branches, and upon the varied congenital malformations of the heart itself. There are among us many who still must see, advise and care for the patient who, because of his venous claudication, his progressive leg edema and stasis dermatitis and ulceration, is hindered from the comfortable pursuit of his daily occupation and sometimes prevented from earning his gainful living. It is to this latter group of physicians that the thoughts herein contained are directed.

There was some inclination to preface this discussion by a review of the literature upon the subject. A starting point would have had to have been made several hundreds of years back[32] (Plate I-a and I-b). This offered no insurmountable problem. A critical selection of articles from the ensuing years would have been more difficult. It was not until 1917 that John Homans[34] made an effort to distinguish between simple varicose ulcer and the so-called postphlebitic ulcer. Since this 1917 report there has been a tremendous outpouring of medical articles, reviews, and books containing numerous methods for cure of this lesion. The various types of ointments, local applications, iontophoresis, supports, injections, operations and many other treatment methods had their many enthusiastic supporters. It is needless to note that the multiplicity of these measures indicates the ineffectiveness of almost all of them. Homans was one of the earliest surgeons to propose radical excision of the ulcer, the underlying fascia and surrounding pathologic skin with the application immediately of a split-thickness skin graft over the denuded area. This procedure, and many similar ones, some more extensive than others, was designed to remove the damaged and diseased tissues in the lower part of the leg; it did not correct the abnormal physiology of the venous circulation of the postthrombotic extremity.

A second wave of enthusiasm then swept the literate members of the profession and there was a second rash of papers, this time dealing with the ligation, excision, stripping and, more recently, homologous replacement of leg veins. Again this volume of papers is staggering and beyond the capabilities of one individual to review with profit.

It is now several years since the last great wave of enthusiastic recording of the incidence of acute venous thrombosis and its embolic sequelae reached its peak. It might appear to the unwary physician that we have reduced most surely and sharply the incidence of this acute entity, have increased most certainly our ability to discern its presence early, that we can anticipate its most likely points of origin and have highly suitable measures for its control. Were these observations so, the difficulties of patients with postthrombotic sequelae would be shortly

* Presented before the Baltimore City Medical Society Friday night, January 4, 1957, in Osler Hall, 1211 Cathedral Street, Baltimore 1, Maryland.

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*Descriptive Account*

OF A

NEW METHOD

OF TREATING

OLD ULCERS

*Of the Legs.*

By THOMAS BAYNTON,
*SURGEON, of BRISTOL.*

The SECOND EDITION,
*Enlarged, Corrected, and conſiderably Improved.*

*BRISTOL:*
PRINTED FOR EMERY AND ADAMS, HIGH-STREET,
AND SOLD BY THOS. HURST, PATERNOSTER-
ROW, LONDON.
1799.

Plate I-a

( 10 )

and every other remedy I was acquainted with that authors had recommended, both alone and conjoined with the most approved internal medicines, *I determined on endeavouring to bring the edges of thoſe ulcers which might in future be placed under my care, nearer together, by means of ſlips of adheſive plaſter*; having frequently had occasion to obſerve that the probability of an ulcer continuing sound depended much on the size of the cicatrix which remained after the cure appeared to be accomplished: and believing also that the natural shield of the part, the true skin, afforded a much more substantial support and defence, as well as a better covering, than the frail one supplied by nature in the common methods of cure.

Plate I-b

of only historical interest. To be sure, additional knowledge has been provided by this abundance of observations over the past 10 years. It requires little more than a perusal of a fraction of the voluminous literature which has accumulated to conclude, however, that each of the suppositions of our ability to anticipate, diagnose, locate and treat efficiently thrombophlebitis is open to considerable question.

It is difficult to determine accurately the incidence of acute deep vein thromboses in the leg and as a corollary, the number of individuals who will develop postthrombotic sequelae. All who have recorded this incidence are impressed by the extraordinary variations in the rate of incidence of the disease in different clinics and even in the same clinic from time to time. It soon becomes quite apparent that these variations are, in part, the natural history of this condition—one might paraphrase this by noting that it appears *un*likely, at the moment, that the problem of treatment of the postthrombotic extremity is a fast disappearing one. It is possible that the present may be one of those relatively "immune" periods erroneously credited to whatever preventive treatment that has been most vigorously instituted within the most recent part of any survey period.

From the observations of Hunter et al.[10], and many others, it has become well accepted that acute thrombi are initiated in the majority of instances in the veins of the calf muscles and it is here that we expect their earliest manifestations. It is distressing then to note that McLachlin and Paterson[11] were impressed most recently by the autopsy findings on 165 middle-aged or elderly

male patients in whom 73 per cent of the venous thrombi arose not from the veins of the legs, but from the large veins of the pelvis and thigh. These necropsy findings are distressing. One of the great expectations from the use of anticoagulant drugs has been the prompt arrest of thrombus progression and its confinement more or less strictly to the general region of its origin. If this site of origin is commonly the muscular veins of the foot or calf, the early initiation of anticoagulant therapies might be expected to protect the femoral and popliteal vessels from damage and the patient from some of the later complications arising therefrom. Bauer[12] has studied both clinically and roentgenographically seven such patients. Quite spontaneously in these patients the original thrombotic process remained confined to the lower leg. When the compensatory venous system was intact these individuals had no edema, no indurative cellulitis and no ulceration. On the other hand, when the compensatory veins were removed, or occluded by thrombosis in the popliteal segment, the patients had to expect edema, induration and in most cases, ulceration. He felt obliged to comment that "in cases of thrombosis the fate of the lower leg stands or falls with the popliteal vein."[12]

That the sites of origin of acute thrombi may lie somewhere between Bauer's[12] 97 per cent origin in the deep veins of the lower leg and McLachlin's 75 per cent in the large veins of the pelvis and thigh, is given some indirect support by Birger[13]. He noted, among 58 patients whose follow-up examinations were made after the lapse of 16–21 years, after the episode of verified acute thrombosis, that at least one-fourth of the patients were free from trouble and three-fourths were suffering from chronic venous insufficiency; two-fifths of them had leg ulcers. It seems possible that most patients without symptoms, after a long interval, may have had a well localized thrombotic episode limited to the muscular veins of calf and foot.

However important venous thrombosis may be in the production of valvular incompetence, it is reportedly not the only etiology in some individuals who present all of the signs and symptoms of the postthrombotic syndrome. Bauer[14] has very recently reported upon 650 cases of proven femoral vein incompetence of whom almost 50 per cent had a lesion other than venous thrombosis as an etiologic factor (Plate II). The most surprising fact in this study was the observation that these patients, when seen,

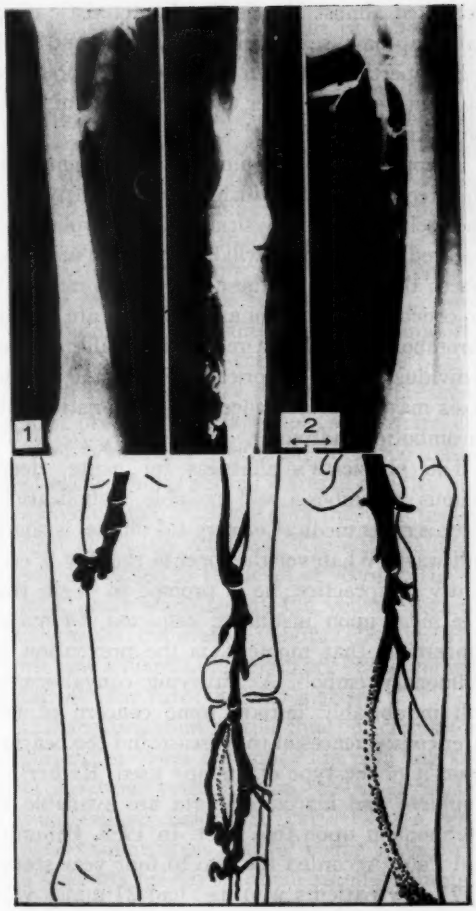


Plate II. Retrograde Phlebography[14].
1) Normal valve function.
2) Incompetent valves.
Lt. postthrombotic.
Rt. idiopathic.

exhibited almost identically characteristic clinical symptoms, sex distribution and wound healing properties, yet their onset was not preceded by pain, fever or other usual incidents of acute phlebitis.

It appears fair to comment, at this point, that the frequency with which patients will present themselves to the physician with a swollen, indurated, ulcerated leg will likely remain undiminished; that many of these individuals may give no conclusive history of antecedent acute venous thrombosis and that a relatively small group of individuals with historical evidence of thrombosis may never evidence a characteristic postthrombotic syndrome.

The physician's alertness for acute, deep, venous thrombosis and possible embolization, after serious medical or surgical illness, is sharp and wary. Whatever the form of therapy is currently his practice, he is prompt to begin this treatment upon justifiable suspicion. Of major concern at that moment, is the prevention of pulmonary emboli. A gratifying convalescence will indubitably initiate some concern of the later consequences of the disease and the bearing upon it of the type of therapy used. Rather incomplete and inaccurate data are available at the moment upon this facet. In 1953, Palumbo and Paul[15] recorded the two to four year status of 21 new patients who had had 27 major vein ligations. Unfortunately, for purposes of evaluation and comparison, some of these patients also had sympathectomies and, in five instances, the ligations were done for the postphlebitic syndrome and not for the acute phase of thrombosis. Bauer[12] recorded in 1942 observations upon 38 patients treated during their thrombophlebitic period with Heparin and 19 patients upon whom no treatment was undertaken. His patients were followed for 3 years. An attempt has been made to compare these observations in Table I.

The follow-up period of the patients included in this chart is most unrealistic if an accurate estimate is to be made of the exact probable incidence of late sequelae of chronic, deep venous

TABLE I

| | No Treatment | Heparin | Vein Ligation | | |
|---|---|---|---|---|---|
| | | | I.V.C. | Iliac | Femoral |
| Edema | | | | | |
| Yes | 19 | 8 | 6 | 2 | 6 |
| No | 0 | 30 | 4 | 3 | 6 |
| Induration | | | | | |
| Yes | 14 | 0 | 1 | 0 | 0 |
| No | 5 | 38 | 0 | 0 | 0 |
| Ulcer | | | | | |
| Yes | 3 | 0 | 2 | 2 | 0 |
| No | 16 | 38 | 8 | 5 | 0 |
| Pain, Heaviness, Tiredness, Burning | | | | | |
| Yes | 18 | 2 | 5 | 3 | 2 |
| No | 1 | 36 | 5 | 2 | 10 |

thrombosis. On the other hand, it offers a point of departure for the observation that in many physicians' hands, anticoagulant methods seem the most suitable and desirable treatment.

Once the temporary incapacity of the acute thrombophlebitis or phlebothrombosis has subsided, one must concern himself with what happens later to this individual. In so many other diseases, once the patient has returned to his occupation, cure may be said to have been accomplished. At so early a stage in the after course of an episode of peripheral thrombosis, only a few individuals will have already experienced severe or disabling distress which will shortly require that they cease their accustomed job. Generally milder symptoms are seen in patients with shorter periods elapsing between their initial episode of phlebitis and their subsequent return to the physician with disabling postthrombotic sequelae. Ochsner, et al.[16], choosing an arbitrary dividing line at two years, after an episode of phlebitis, found that in less than this period, 32 per cent of patients had mild symptoms (mild to moderate edema and slight to no pain or disability), 51.3 per cent had moderately severe disease (moderate edema and pain; disability limiting essential activities) and

only 16.7 per cent had severe symptoms. When more than two years had elapsed since the episode of acute phlebitis only 13.3 per cent of patients had mild disease, 48 per cent had moderate symptoms and 37.9 per cent had severe, disabling symptoms.

These percentages are, in general, similar to those observed by many others and are not necessarily unusual. The explanation for them, on the other hand, is not simple; the reason for one individual developing disabling symptoms within one year while another of like age and comparable severity of disease does not develop these same manifestations for 20 years, does not admit an obviously simple answer. Linton[17] has stated that the thrombotic sequelae with the exception of pain and edema appear only after the deep venous system becomes recanalized. He feels that this occurs in almost all instances and may do so within one year. Bauer[12] has pointed to additional factors which may also play a part in the origin of these phenomena. He has suggested that the saphenous system, under the stress of a persistent venous over-distension, becomes the seat of pronounced degenerative changes within the venous walls themselves. It is not unusual for many of these same individuals to have recurring episodes of thrombophlebitis, possibly from direct trauma, adjacent infection, stasis, vascular allergy or from the injection of sclerosing solutions. It seems possible to accept all of these as factors in the later production of induration and ulcerations of the lower leg.

Perhaps at this point we might divert our attention away from the affected patient for a moment to look at some of the normal and abnormal circulatory phenomena which may pertain to the venous system in the lower extremity.

It is conceded as proven that the fluid transfer across the capillary membrane is regulated by the balance between the hydrostatic pressure within the blood vessels and the colloid osmotic pressure of the plasma. The colloid osmotic pressure of plasma rarely exceeds 30 mm. Hg.[1] When capillary pressure increases to more than 30 mm. Hg., fluid should be lost through the capillary walls and edema occur. Actually, when a person stands quietly in the erect position, the venous pressure rises to levels several times greater than the colloid osmotic pressure of the plasma—within about 60 seconds from the time a normal subject is tilted from the supine to erect position the venous pressure at the ankle increases very rapidly to a plateau pressure value of about 90 mm. of mercury[2]. This represents the approximate hydrostatic pressure required to support a column of blood from the ankle to the base of the heart. The capillary pressure, then, exceeds osmotic pressure by a factor of two or more, and a rapid transudation of fluid into the tissues must occur. Under normal states of activity fluid loss from capillaries is insignificant[21] and protein is most efficiently retained. When the capillary pressure is raised to the level of 90 mm. Hg., as it is in quiet standing, as the venous pressure rises and is maintained above 60 mm. Hg., significant amounts of protein are lost along with water into the extravascular spaces[21].

The accumulation of this fluid, of circulatory origin, in the lower extremities of standing subjects has been verified upon several occasions. Turner and her associates[3] carried out a series of observations upon healthy young women college students by having them stand 15 minutes in a water-filled container deep enough so that water came well above the knees and of approximately normal skin temperature. Observations were made in both winter and summer. The progressive increase in volume after 15 minutes of quiet standing varied from 175 cc. to 256 cc. of water displacement. Further evidence of these changes was given by Waterfield[4, 5]. Male subjects standing for 40 minutes in the erect position demonstrated a swelling of the leg which varied between 60 and 120 cc. Blood volumes determined by him by the carbon-monoxide method showed a fall, primarily in the plasma fraction, of an average of 15% of the total plasma value in these young men. There was an accompanying increase in the plasma protein con-

centration such as would be expected if the globulin fraction alone did *not* diffuse through the capillary walls. There was a minimal (4%) loss of cell volume. A period of recumbency of comparable duration resulted in shrinkage of the leg of about 60 to 80 cc. and this continued slowly for an additional undetermined period of time. A period of exercise followed by one of recumbency resulted in a loss of 100 to 120 cc. in 40 minutes. Muscular relaxation, contraction and relaxation again, produced a variation of about 70 cc. in the volume of the leg.

These observations, taken together, indicate that the postural swelling and shrinkage of the leg, the postural diminution and increase of plasma volume, the postural changes in percentage cell volume and plasma protein percentage, in the normal individual, are all manifestations of the passage into and out of the lymph spaces of the diffusible constituents of the plasma. The collective area of capillary wall available for fluid interchange is relatively enormous. Krogh[3] estimated that the total surface of capillary wall in the body of an average sized man must exceed 68,000 square feet. The total collective area of capillary endothelium can be visualized as a microscopically thin membrane 3 feet wide and over four miles long.

Turnbull[6] calculated these changes in the lower extremities during standing and walking for 10 minutes, to be approximately 20 cc. per minute. This fluid was regained, evidently, by the blood stream during a period of rest in the supine position.

Loss of fluid upon quiet standing at the rate of 20 cc. per minute cannot continue indefinitely, quite obviously, or drastic circulation disturbances would result. The number one mechanism concerning which there is the most clear-cut information, to reduce this loss of fluid from the dependently located capillaries, is the venous valvular-voluntary muscle pumping mechanism. The other mechanisms which might reduce the volume of transudation of fluid are not completely understood; the first of these is increased lymph flow. A second is an increase of tissue pressure which must effectively decrease filtration pressure across the capillary membrane. Finally, from human centrifuge experiments, it is suggested that the vascular system of the lower extremities is inherently much more resistant to the formation of edema on a hydrostatic basis than, for example, is the vasculature in the upper portion of the body.

One of these factors, the effect of tissue fluid accumulation upon the rate of filtration, was studied by Landis and Gibbon[7]. They noted that the rate of filtration produced by any given venous pressure decreased rapidly as fluid accumulated in tissue spaces, and that this reduction was greatest in the first 30 minutes of venous congestion. Free absorption of tissue fluid is decreased proportionately to the degree of loss of tissue elasticity[9]. Perhaps the most important mechanism for minimizing edema in the normal leg, is the contraction of stripped muscles which forcibly squeeze out and propel blood towards the heart. Reflux of the blood column between muscular contractions is prevented to some degree by the venous valvular mechanism. The occurrence of edema shows in itself, however, that the power of tissues to resist the accumulation of tissue fluid is a limited one. Bonninger[29] found this when he demonstrated that living tissues are imperfectly elastic and frequently fail to return to their original length when tension is removed.

When capillary pressure is raised to 60–80 mm. Hg., protein as well as fluid is lost in significant amounts, thus effectively decreasing plasma colloidal osmotic pressure and favoring greater filtration into tissue spaces. It should be recalled that simple mechanical edema, however, may be only one of the factors to excite proliferation of connective tissue in the subcutaneous space. Whatever these factors are, experience has made us aware that once this late phase of postthrombotic edema and induration is entered into, the return of an extremity to its prephlebitic size, by simple rest and elevation or by the

ambulatory use of external compression means, is not often attainable. The continued presence of a fluid transudate, rich in protein, in the subcutaneous tissue spaces suffices to initiate a fibroblastic response the end result of which is a firm, thick, sclerotic collar.

Thus, it would appear that at all times, with the patient in the upright position, the pressure within the leg veins is above the colloid osmotic pressure of the blood, even during walking. Yet this is not usually associated with gross edema formation[22]. Presumably, lymph vessels are capable of draining adequately the relatively limited tissues drained by these veins. In patients with varicose veins, the transudation of fluid is only slightly above normal and edema is minimal. With incompetent valves in the communicating veins, such as may exist after destruction of these valves by an episode of thrombosis, the high pressure in the deep venous system is transmitted to the superficial system. The valvular mechanisms in this system will withstand this pressure for a short period only before they too, if not already damaged, will become incompetent. It is at this point that the lymphatic drainage channels will most surely decompensate and clinical edema supervene. Drinker[23] has suggested even that the lymphatic trunks too, may be "varicose." A further factor now enters to compound the difficulties of this overloaded lymphatic system. As a result of the inflammatory reaction surrounding the femoral vein at the time of the acute phlebitis, there may be varying degrees of lymph channel obstructions from the progressive scarring in this perivenous collar[24].

It would appear from all that is known to date of the postthrombotic state that, in its simplest form, the peripheral venous disorder largely arises from the difficulties associated with the continuous passage of venous blood from the dependent extremity toward the heart against gravity. Muscle activity and tonus provide one of the principal forces producing this flow. The direction of flow is determined largely by the push of blood from the capillary bed, the negative intrathoracic pressure and the vein valves. The upright position imposes a substantial load upon each of the mechanisms, and it can be assumed that the margin of safety or competence is not a great or wide one.

Some of the changes in normal tissues, upon assuming the upright position have been recorded in the preceding paragraphs. In light of some of the proposed methods of treatment for patients with the more severe symptoms of the postphlebitic state, additional information may be gained by determining the ambulatory, functioning pressures and appearance of the postphlebitic venous system.

Immediately following destruction of a major vein by thrombosis, the pressure in the venous system peripheral to that point rises. Eventually, probably most thrombosed veins recanalize, but when they do, the valve leaflets are trapped in the sclerotic walls of the vein and are functionless. However, it seems likely that not all thrombosed veins necessarily recanalize, and the ambulatory venous hypertension so characteristic in these patients could be due to (1) residual venous obstruction, (2) the occurrence of venous reflux in valveless veins, or (3) a combination of these two.

The venous reflux pattern in the normal extremity was studied by Moore[27] by the use of radiopaque media. In the normal leg there was generally some distal regurgitation of the medium past several valve stations after it reached the deep system. The material cleared readily from the deep system with exercise. The deep venous system failed to opacify by this method only in those patients in whom the deep system was obstructed, or when injections were made into a completely incompetent superficial vein with total, unimpeded retrograde flow. The deep venous trunk, even when recanalized in the postthrombotic state, will opacify in quiet dependency unless the superficial system is wholly incompetent. Further observations by this method are urgently needed in order to clarify

some of the suppositions about the character of venous flow in postthrombotic states.

Possibly somewhat less direct, but surely more informative, are the observations of De Camp[25, 26] and his colleagues upon the venous pressure patterns in the postthrombotic extremity. These observers noted a 50 per cent to 90 per cent fall, in the standing venous pressure, upon brisk walking. Upon cessation of exercise, the pressure promptly but slowly returned directly to the preambulation level. The recumbent foot venous pressures were the same in the postphlebitic patient as in the normal. Upon ambulation, pressures began to fall slowly in the postphlebitic patient but the degree of fall was small, ranging from 16 to 52 per cent of the standing pressure. As in the normal subject, the pressure remained constant during exercise once the effects of ambulation had been established. On cessation of walking, the pressures in all instances returned directly to the preambulation level, but the rate of return was, on the average, twice as rapid. Finally, two patients were studied who had had recent superficial femoral and popliteal vein ligations for treatment of the postphlebitic syndrome and an additional nine patients, 6 months to 6 years after deep vein ligation. These patients, too, had ambulatory venous hypertension usually of somewhat greater degree than that seen in the postthrombotic state alone. These observations must be given some profound consideration when a method of treatment is planned for the patient with disabling postphlebitic symptoms.

It is anticipated that with the passage of time a variable but increasing number of patients will develop the lower leg syndrome sometime after an episode of venous thrombosis. Zilliacus[28] in a series of 680 patients, reported that 90 per cent had mild pain or discomfort, 50 per cent had chronic induration and 20 per cent had ulcers. The acute episode had occurred 6 to 14 years prior to his report in 1946. Since Heparin was not introduced into clinical use in Sweden until 1937, and Dicumerol not until 1942[13], none of his patients had been treated by the longer acting anticoagulants and few of them by Heparin. It is encouraging to note from a later study by Hojensgard[20] that on the whole, the sequelae of deep vein thrombosis appear to reach their maximum within the first 5 years or so, and that after that time the state appears to remain fairly stationary. He was able to note that the incidence of leg pain decreased as the years went by.

It is the present expectation that the incidence of these late disabling features will be reduced not only by more active preventive measures, but by more prompt and specific medications for the prevention of thrombus progression once it is detected.

Whether or not we shall surely benefit according to our present expectations will require a period of expectant waiting of perhaps 20 years before assessment is undertaken. Further, the answer will be confused by an indeterminate number of patients whose acute thrombophlebitis or phlebothrombosis will remain undetected early, or by those whose symptoms and signs are totally masked by adjacent disease or injury. Undoubtedly, some patients will not see a physician during their episode of acute disease. The effectiveness, too, of our present day prophylactic measures is open to the vagaries of a disease which seems to wax and wane without obvious reason. In summation, then, we shall very likely need to continue to give some thought to the patient who presents himself with all manner of postthrombotic sequelae.

The clinical picture presented by so many patients is a familiar one. It is usually varied and complex and is often as much a reflection of the individuals' economic status or his constitutional sufficiency as it is of the disease itself. It is possible frequently to divide roughly these patients into several groups according to the signs and symptoms which they present.

I. Individuals with edema, pigmentation, induration, eczematization and ulceration. This group accounts for possibly 60 per cent of pa-

tients[18]. The symptoms and signs are progressive and regressive but always present except at complete bed rest.

II. Causalgic-like pain syndromes without anatomic nerve distribution, often with stocking paresthesias and vasomotor skin changes.

III. Choked-leg syndrome. There is marked venous congestion with prominent venous distention and cyanosis. These are the patients who may have a bursting-type pain when the leg is dependent.

IV. Saphenous neuritis. These patients usually have excruciatingly painful ulcers on the medial supramalleolar area. A constant diagnostic finding has been a spot of exquisite tenderness to deep pressure over the point where the saphenous nerve pierces the deep fascia of the leg[19].

Undoubtedly, there are other characteristic groups of patients and surely many combine the symptom complexes of these several categories. To some extent, however, this grouping of patients leads us to a somewhat less than indiscriminate use of one method of treatment for all patients. Certainly for the patient with saphenous neuritis a neurectomy is the initial step in treatment of the ulcer. Many of the previously indolent ulcers are reported to heal within 2 to 4 weeks following operation[19]. Not all patients are so fortunate and supplemental procedures may be required.

A small group of patients, perhaps 15–18 per cent, will have symptoms and signs which are pathognomonic of vasomotor over-activity. Peripheral pulses are sometimes diminished. The pain complex, throbbing in character, becomes established early in convalescence from the acute disease. The leg may be even faintly cyanotic, minimally swollen and perhaps "numb" below the knee. There is usually hyperhydrosis and the skin of the leg is cool to touch. Resection of the lumbar sympathetic ganglia should be preceded by a test of anesthetic blocking of the chain. When symptomatic relief is attained by this test, sympathectomy may be indicated. Users of this operation should recognize its undesirable sequelae. Sympathectomy acts on the vasomotor mechanism only; it does not avoid or prevent the venous stasis, one of the principal and almost universal sequelae of the postthrombotic period, and edema may be enhanced postoperatively.

A very small group of patients may exhibit profound venous stasis with marked congestion and cyanosis. After a period of quiet standing the leg may feel as though it will burst. Edema frequently is not marked. For a time operation upon this group of patients was considered barred presumably because it was thought that the venous channels were carrying their maximal load, and surely they were, and any interruption of these vessels might be catastrophic. Homans[18] was one of the earliest to suggest that the recanalized major vascular trunks were the likely source of this congestive hypertension. He suggested ligation of the major trunk.

Finally, the vast majority of patients will exhibit the standard gamut of edema, induration, dermatitis and ulceration for which any number of operative and non-operative measures have been devised, the latest of which is without qualification, always said to be the best.

Some years ago, because of the known valvular venous incompetence which exists following an episode of venous thrombosis and subsequent vein recanalization, we[35] became interested in deep vein ligations upon patients who exhibited essentially the common chain of postthrombotic symptoms.

The total group so treated numbered 72 patients. Six of these are dead of unrelated disease leaving a total of 66 patients. Upon 9 of these the inferior vena cava was ligated, upon 2 patients the common iliac was ligated, thirteen patients had their common femoral veins ligated, thirty-two their superficial femoral veins, and 10 patients had popliteal vein ligations. Five of the patients who were subjected to popliteal vein ligation had bilateral operations; thus, a total of 71 veins were ligated for chronic postphlebitic states. The duration of follow-up was 6 to 12

years and averages 8 years. The late results are depicted in Tables II to VII.

In general, one is impressed with the unpredictableness of this method of treatment. At the time of institution of treatment, no particular attempt was made to set aside certain groups of patients for variation in the method employed. For this reason any attempt to determine the effectiveness for any particular level of ligation or for any isolated category of patients is useless. As might be anticipated, an effort was made to remove superficial varices when they were present and leg ulcers were excised and skin grafted upon the defect when necessary. Perhaps the best overall results are apparent in the large percentage of healed ulcers following popliteal vein ligation. On the other hand, each of these patients is thought to have contributed quite remarkably to his or her own success by persistent and meticulous care of the extremity over this follow-up interval.

The conclusion reached at this time is that of most surgeons interested in this group of patients; the operation of deep vein ligation has little to recommend it as an indiscriminate method of therapy in patients with the postthrombotic syndrome. It may be used in a thoughtfully selected few patients where popliteal vein ligation may be a conceivably useful

TABLE II

*Ligation of Inferior Vena Cava in Nine Patients*

| Sequelae | Pre-Operative | | Post-Operative | | |
|---|---|---|---|---|---|
| | Unilateral | Bilateral | Improved | Same | Increased |
| Edema | 4 | 4 | 4 | 1 | 4 |

| | | Healed | Unhealed | New | Recurrent |
|---|---|---|---|---|---|
| Ulcer | 6 | 1 | 5 | 4 | 2 |
| Pain and/or fatigue | 7 | 7 | | | |
| Varicosities | 4 | 4 | | | |

TABLE III

*Effect of Femoral Vein Ligation on Pain and/or Fatigue*

| | Pre-Operative | | Post-Operative | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | Rest | | | Exercise | | |
| | Rest | Exercise | Diminished | Same | Increased | Diminished | Same | Increased |
| 1950 | | | 36% | 64% | | | 50% | |
| 1955 | 26 | 31 | 37% | 45% | 20% | 35% | 61% | 4% |

TABLE IV

*Effect of Femoral Vein Ligation on Edema*

| | Pre-Operative | | | Post-Operative | | | |
|---|---|---|---|---|---|---|---|
| | No edema | Unilateral edema | Bilateral edema | No edema | Diminished edema | Same as preoper. | Increased edema |
| 1950 | | | | | 60% | 23% | 17% |
| 1955 | 9% | 56% | 36% | 13% | 40% | 32% | 14% |

TABLE V

*Effect of Femoral Vein Ligation on Ulcerations*

| | Pre-Operative | | | Post-Operative | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | Grafted 12 | | |
| | Ulcers in entire series | Unilateral ulcers | Bilateral ulcers | Healed | Unhealed | New | Recurrent | Graft failed | Broke down | Healed |
| 1950 | 35 | 80% | 20% | 57% | 43% | 23% | | | 33% | 66% |
| 1955 | | | | 43% | 57% | 23% | 43% | 8% | 67% | 25% |

TABLE VI

*Relation of Sequelae to Level of Femoral Vein Ligated*

| Level of Ligation | Number of Patients | Edema | | Ulcer | Varicosities | |
|---|---|---|---|---|---|---|
| | | Absent or improved | Increased | Healed | Absent | New or recurrent |
| S.F.V. | 32 | 47% | 22% | 53% | 38% | 56% |
| C.F.V. | 13 | 69% | 0% | 69% | 46% | 54% |

TABLE VII

*Ligation of Popliteal Vein in Fifteen Extremities*

| Sequelae | Pre-Operative | Post-Operative | | | |
|---|---|---|---|---|---|
| | | Healed | Unhealed | New | Recurrent |
| Ulcer | 100% | 80% | 20% | 7% | 33% |

| | | Improved | Same | Increased |
|---|---|---|---|---|
| Edema | 53% | 33% | 14% | 53% |
| Pain and/or fatigue | 75% | 27% | 53% | 20% |
| Varicosities | 53% | 33% | 53% | 14% |

adjunct to such measures as lumbar ganglionectomy, removal of the incompetent saphenous system and excision and skin grafting of large, chronic ulcers. Support for this observation is not forthcoming from any of the studies of venous pressure levels on patients after such ligations. However, the clinical experience reported by some surgeons and, to a small extent, by the late results in our own patients, suggests that by careful selection such operations may be helpful and justified.

There seems to be a greater rationale therefore, for the scrupulous avoidance of edema, be it by bed rest with leg elevation or by suitable bandaging, and by the prevention or correction of the further complications by the removal of associated, incompetent secondary varicose veins by lumbar sympathectomy, by neurectomy, and by skin grafting. The instructions so lucidly set forth by Luke[30] in his suggested "The New Way of Life" seem a worthy approach to this course of prevention:

THE NEW WAY OF LIFE

1. Wear your elastic stocking from the time you get out of bed until you retire, with the exception of bath time. The stocking should be renewed every three months, and it is best to have two stockings that can be alternated for cleaning purposes.
2. Do not stand for more than thirty minutes without sitting down for fifteen minutes and elevating the leg on another chair. When standing, get into the habit of flexing the toes in your shoes and frequently rising on tip toes.
3. Plan your day so that you can lie down for two half hour periods and elevate your leg to a 45 degree angle. The back of a small straight backed chair is useful for this purpose.
4. Whenever you sit down, elevate your leg on a foot-stool, chair or chesterfield.
5. At night raise the foot of the bed on blocks about six inches.
6. Apply a bland cold cream to the affected skin at nights about every second day.
7. Avoid irritation to the involved leg, especially in respect to sunburn and hot water bottles.
8. Be extremely careful to prevent bumping, bruising or scratching the affected leg.

The solution for the relief of these patients is beset by the need, to date, of a measure of treatment which demands a minimum of continuing meticulous care for the damaged extremity by the individual. At this time no such short-cut to "cure" is apparent.

It seems proper to point out that the diligent and intelligent use of our present, even though time-honored, methods of treatment and the almost certain exclusion of deep vein ligation in all but the rare instance does not absolve us from a disinterested, dilatory approach to the care of these individuals. A clearly defined, vigorous and promptly executed program is of considerable importance to these individuals.

In the course of pursuing this vigorous, well planned treatment program, an occasional patient is encountered who does not prosper under what must be considered a correct, well planned and executed program. For the most part, these will be patients with ulcers of varying size in the inner, supramalleolar area. These individuals may or may not have obvious varices in the saphenous system and, if they do, may have recurrent ulceration despite adequate stripping of these vessels. Vigorous application of compression pads over these ulcers will commonly permit healing, if applied continuously, but recurrence may be prompt once this course is abandoned.

Such a response is characteristic of what has been described as the "ankle blow-out" syndrome[31], and is based upon a purely local venous valvular incompetence. From many dissections it has been shown[31] that from the middle of the leg to just below the internal malleolus the major saphenous vein has few or no branches as a rule. Proximal to and beyond this it, of course, has many branches. The numerous subcutaneous

veins on the mesial surface of the leg drain directly into the deep venous system through perforating veins, at least two and usually three in number, which pass just anteriorly to the soleus muscle to empty into the posterior tibial vein. There is almost always a communication between the highest perforator and the greater saphenous vein. There is considerable variation in the branches of these perforating veins and in the way in which they communicate with the saphenous system.

The mechanism of the production of induration and ulceration in this area is like that elsewhere. When the calf muscles contract and compress the deep veins, blood will pass normally toward the right heart. When the valvular system is wrecked, muscular contractions in the calf area squeeze blood in both directions and this frequent, high-pressure back-flow about the ankle results earliest in multiple, small, tortuous, dilated veins directly under the skin of the ankle region. Induration and ulceration here are usually initiated by local trauma, eczema, infection, subcutaneous hemorrhage or an area of thrombosis.

Such an area requires wide incision, excision of the ulcer itself, ligation of communicating and perforating veins and, above all, a meticulous and gentle surgical technic, for prompt healing in these damaged tissues is precarious indeed.

From these considerations of the problems exhibited by the postphlebitic patient, limited as they are, the conclusion may be reached that a critical analysis of the many proposed treatments for this disease carry with it little assurance that any one of them will offer more than amelioration of some of the patient's signs or symptoms. Insofar as can be determined, a good and prolonged recovery is predicated for the most part upon the tedious, scrupulous, personal care of the part by the patient. The surgeon's contribution to further improvement is predicated upon a realistic evaluation of the existing patho-physiologic changes. Correction of some of these is possible and its accomplishment attended by some further improvement. On the other hand, I do believe it important not to extend the proposed surgical measures beyond the point of precisely known return. The fact that several measures are at hand, that the execution of each carries a minimal hazard to the patient, and each is known to have helped certain individuals who had a similar symptom complex, should not indicate that the combination at once of all of these known measures in all similar patients is the initial, and the only logical treatment program. A large number of individuals will likely obtain relief of symptoms and perhaps healing of ulcers from a strict treatment program strictly adhered to and without the necessity of hospital admission. Others will not be so fortunate. Some will require multiple operative procedures before a maximal benefit is attained and this should not be deprecated.

It has been suggested recently that the successful transplantation of homologous veins, with their intact valves, is the logical goal of today's vascular surgeon and some reported early results of this technic go far to support this hope. Perhaps this is the long-awaited ideal solution for these patients.

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# SCHISTOSOMIASIS MANSONI IN MARYLAND

## Report of Case[1]

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Infestation with Schistosoma mansoni is exceedingly rare in Maryland. Prather (1), of the Maryland State Department of Health, states that there is no record of it until 1951, when it was found at the University Hospital in Baltimore in a Puerto Rican migratory farm laborer working in Carroll County. Ova of this parasite were found in the feces of 10 of his 32 companions. With increase in immigration from the Caribbean area, more cases are to be expected and require careful differential diagnosis as the infection simulates, closely, other diseases. The present case simulated carcinoma of the sigmoid colon.

This man, a white Puerto Rican of 26 years, had come to Wicomico County in 1954 as a farm laborer spending a total of 3 years in the Peninsula Area. He had never been out of Puerto Rico previously. He had been in fair health until the onset of this illness and did not remember any previous disease. In the 6 months before admission he had lost 20 pounds. For 3 months he had intermittent diarrhea, feeling of fullness in the right upper abdominal quadrant, loss of appetite, nausea, pain usually at night and not related to ingestion of food. A mass was felt by the patient in the left lower abdominal quadrant. One week before admission he vomited blood. On the following day he had tarry stools, which became yellow in a few days.

He was admitted to Peninsula General Hospital in Salisbury, Maryland, on March 15, 1955. Examination showed a young man of poor nutrition, with dehydration and evidence of weight loss. There was no jaundice. The significant findings were abdominal. The liver was enlarged, chiefly to the left, was not tender and not palpably nodular. It could be felt 2 inches below the xyphoid process. In the left lower abdominal quadrant, there was a non-tender, mobile mass about 3 inches long. Rectal examination revealed a feeling of fullness in the upper rectum and tenderness on the left side.

Blood showed a mild anemia, hemoglobin of 10.4 grams per cent, red cell count of 3,900,000. Leukocyte count was 9,100 with differential showing 36 per cent of eosinophiles, otherwise not remarkable. Icteric index was 4 units; Bromsulphonephthalein test showed no retention of the dye in 30 minutes. Standard test for syphilis (V.D.R.L.) was negative. Urine was not abnormal. No parasites nor ova were demonstrated in numerous stools.

X-rays of chest and upper gastro-intestinal tract showed nothing unusual. A barium enema revealed narrowing of the junction of the descending and sigmoid colon (Figure 1).

Following admission, treatment by hydration and multiple transfusions of whole blood resulted in some general improvement. A proctoscopic examination on his second hospital day showed an annular obstruction 20 cm. from the anus. The mucosa was friable and bled easily. A satisfactory biopsy was not obtained. Under the impression that the lesion was a carcinoma of the sigmoid, a laparotomy was done the second week. A length of upper sigmoid colon was found to be greatly thickened and firm. Small masses could be felt in the mesosigmoid, greater omentum and ligamentum teres. The liver contained many firm nodules, from 1 to 3 cm. in diameter. The spleen was enlarged. The rest of

[1] Submitted April 25, 1956, for publication in the MARYLAND STATE MEDICAL JOURNAL.

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FIG. 1. Radiograph of abdomen following barium enema, reduced 10/35.

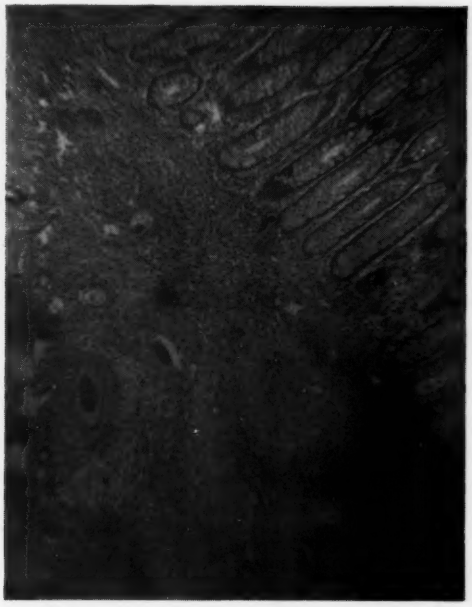

FIG. 2. Mucosa of Sigmoid Colon, microphotograph × 80.

the gastro-intestinal tract showed no lesion. The multiple nodules were considered metastatic carcinoma, from primary sigmoidal site.

The surgical specimen included a portion of large intestine, 13 by 3 cm. The central portion had a firm white wall 0.8 cm. thick. Mucosa was pale and showed irregular thickenings. Attached mesentery showed no visible nodes but the mesenteric serosa had a firm, pale, thickened patch. A separate piece of omental fat, 16 by 7 cm. contained near one end an area of thick, firm white tissue, 4 by 3 cm.

Sections of the intestinal wall showed an intact mucosa and no sign of carcinoma. Throughout the thick portion, from the submucosa through the serosa, were embedded fragments of eggs of a worm. The fragments were surrounded by giant cells of foreign body type, lying within circular granulomas which contained neutrophiles, eosinophiles, lymphocytes and plasma cells. In some places, circular foci of epithelioid cells were found (Figure 2). Similar inflammatory areas were found in the firm

FIG. 3. Greater Omentum, showing bodies of worms in dilated veins, microphotograph × 80.

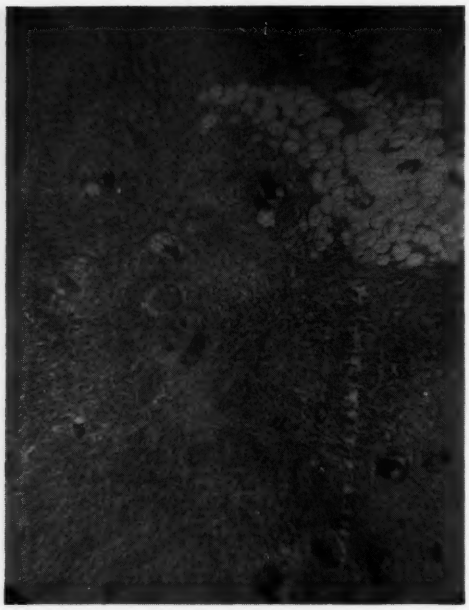

FIG. 4. Greater Omentum, showing ova in granuloma. One ovum shows the characteristic lateral spine, microphotograph × 80.

portions of mesentery and omentum. In the latter, bodies of worms lay in dilated veins (Figure 3). The worms resembled Schistosoma as described by Ash and Spitz (2). Col. Ash examined the slides and also identified the ova as from the same genus. A few of the eggs had the lateral spines of Schistosoma mansoni (Figure 4).

The immediate post-operative course was stormy. A total of 5 pints of blood were given, one every other day. On two occasions vomiting of material resembling coffee grounds and massive diarrhea occurred but were controlled by re-instituting intravenous feeding. Specific Fuadin therapy was begun March 31 and continued until discharge on April 15, 1955, with total administration of 40 cc. of Fuadin. He was discharged to the medical clinic with another course of Fuadin to be given and with repeated examination of feces for ova. Subjectively he showed great improvement and states that he is free from symptoms.

SUMMARY

A case of infestation of Schistosoma mansoni is reported which simulated carcinoma of the lower intestine.

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# TRACHEOTOMY WITH BRONCHOSCOPY*

HUGO A. SACCHET, M.D.

Cases of laryngeal obstruction requiring tracheotomy because of inadequate airway have been routinely bronchoscoped. During the past several years there have been occasions to tracheotomize some 50 patients because of an insufficient airway. These cases comprised: narrowing of the glottic chink due to far advanced carcinoma of the larynx; subglottic edema due to prolonged intratracheal anesthesia; tuberculous laryngitis; laryngeal edema due to laryngeo-tracheo-bronchitis; papillomata of the larynx; laryngeal trauma; severe burns of the head and neck; skull injuries with loss of consciousness and cerebral accidents.

This discussion does not deal with the "slash" type tracheotomy, but with those elective and emergency tracheotomies done in the hospital with proper personnel and equipment. One cannot predict the time of laryngeal closure so the wise operator does his tracheotomy when re-

* Submitted March 14, 1956, for publication in the MARYLAND STATE MEDICAL JOURNAL.

spiratory embarrassment is minimal and avoids the hazards encountered when the patient becomes markedly dyspneic. The use of the Mosher "life saver" will eliminate some of the pitfalls of the emergency tracheotomy but the use of the bronchoscope to re-establish regular respirations before tracheotomy is another excellent "life saver."

In all obstructive cases it was possible to insert a bronchoscope either directly or through a laryngoscope after first visualizing the larynx. In adults, the size of the scope was governed by the extent of the lesion and the size of the glottic opening as visualized by indirect laryngeal (mirror) examination. In the majority of these cases a 5/30 Jackson bronchoscope was passed. In those adults in which the glottic opening was considerably narrowed a 4/30 bronchoscope was inserted and if necessary a portion of the carcinoma or papillomata sheared off with the passage of the scope. In children requiring tracheotomy a 3½ or 3 millimeter bronchoscope was inserted after visualizing the larynx with an infant laryngeoscope.

The bronchoscope was passed usually to the region of the lower trachea or to just above the carina. Following the passage two strips of adhesive are wound about the proximal end of the scope and adhered to the patient's face. The patient is then placed in the tracheotomy position with a small sand bag underneath the shoulders and a routine low midline tracheotomy done.

It has been found that with a bronchoscope in situ a much more orderly tracheotomy can be accomplished as the element of time is no longer a major factor. The adult patient is much more cooperative, for he has lost his dyspnea and apprehension by having an adequate airway insured with the passage of the scope. In a number of cases the upper portions of the tracheo-bronchial tree were examined with the scope and excessive secretions removed by suction. In children with laryngo-tracheo-bronchitis the material obtained by suction was collected in specimen bottles and cultured for organisms, thus aiding in the diagnosis.

As the majority of the pre-tracheotomic patients demonstrate some degree of cyanosis it has been found extremely beneficial, after the passage of the bronchoscope, to inflate 3 to 4 liters of oxygen per minute through the side arm of the scope—this has been particularly helpful in children with laryngeal and subglottic edema. In tracheotomizing infants one often finds it difficult to keep the trachea within the operators field and grasp, because of its size and lack of structure to the cartilaginous rings. With an infant scope in place some of the hazards are eliminated for the bronschoscope well outlines the trachea and insures its position to the operator.

During the course of the tracheotomy, after a section of the second or third tracheal ring has been removed, the bronchoscope is slowly withdrawn to a region just above the incised tracheal opening and kept in place until it is certain that the tracheotomy tube is functioning properly. The bronchoscope is then removed completely and the tracheotomy completed.

## Summary and Conclusions

In some 50 cases of laryngeal obstruction requiring tracheotomy there has been routinely passed a 5/30 or 4/30 bronchoscope in adults and a 3½ or a 3 millimeter scope in children. There were no operative deaths in any of the cases.

With the elimination of the time factor a much more orderly tracheotomy can be done and thus eliminate some of the post-tracheotomy complications which often ensue.

The bronchoscopic procedure gives the operator an opportunity to visualize the tracheobronchial tree and remove any secretions which may exist and use the aspirated material as an aid to diagnosis.

In young infants the bronchoscope well outlines the trachea and facilitates surgery.

*251 E. Baltimore St.*
*Hagerstown, Md.*

# Component Medical Societies

## ALLEGANY-GARRETT COUNTY MEDICAL SOCIETY

LESLIE E. DAUGHERTY, M.D.
*Journal Representative*

### Officers of Allegany-Garrett County Medical Society

The following officers were elected for the year—1957:

President—Dr. Benedict Skitarelic, Cumberland
Vice President—Dr. Hilda Jane Walters, Frostburg
Secretary—Dr. David H. Miller, Cumberland
Treasurer—Dr. Thomas F. Lewis, Cumberland
Delegates—Dr. William A. VanOrmer, Dr. Donald B. Grove, Cumberland
Alternate Delegates—Dr. Arthur Jones, Oakland; Dr. Carlton Brinsfield, Cumberland
Censor—Dr. Wylie M. Faw, Cumberland

Dr. Leslie E. Daugherty remains Journal Representative.

Your Journal Representative attended the First Sectional Meeting of the College of Surgeons, in San Juan, Puerto Rico, in January. Puerto Rican Fellows of the American College of Surgeons were hosts to the First Sectional Meeting, in the 1957 series, when they welcomed their confreres to San Juan, on January 16th. In cooperation with the University and its School of Medicine, the members of the Puerto Rico Chapter gave a three day scientific and cultural program.

Surgeons and their families from all over the States sailed by ocean liner on the steamship Homeric. Headquarters in Puerto Rico, were at the Caribe Hilton. Places visited on the cruise were Havana, Cuba, Panama Canal and seaports in South America.

All surgeons will want to attend the American College of Surgeons Sectional Meeting in Washington, D. C., March 18th. to 20th. Excellent program.

The April Issue of the Maryland State Medical Journal will be dedicated to Allegany-Garrett County Medical Society. The Society deeply appreciates the opportunity to participate in one of the major activities of the Medical and Chirurgical Faculty. Nothing has contributed more than the Journal, in bringing about a better understanding of what the Society is accomplishing in public

Drs. J. Stegmaier, A. Twigg, F. Whitworth, B. Skitarelic and S. Jacobson.

Drs. W. Faw, W. F. Williams, H. Eliason and L. Daugherty.

Drs. S. Weisman, S. Jacobson, H. Tolson and H. Eliason.

health, advancement of the Medical sciences, togetherness of purpose and promotion of goodwill among the Medical Fraternity. United We Stand, Divided We Fall.

### Dr. Whitworth Entertains Hospital Staff

Completing a successful year as president of the Cumberland Memorial Hospital Staff, Dr. Fuller B. Whitworth entertained the active staff at his tastefully decorated home in the Dingle. He was assisted by Mrs. Whitworth, who served a sumptuous dinner after refreshments.

Shop talk was dispensed with and many topics for discussion included deep sea fishing, hunting, flying and music. Dr. Whitworth proved an entertaining host and recounted many seafaring experiences, with evidence of his catch on the walls of his recreation rooms.

## DORCHESTER COUNTY MEDICAL SOCIETY

ALFRED R. MARYANOV, M.D.

*Journal Representative*

The December Meeting of the Dorchester County Medical Society was held at the Cambridge Country Club on Thursday, December 13, 1956. The members of this society had their wives as their guests. Dinner was served prior to the business meeting. Elections were held.

New officers elected and installed for the ensuing year were:

Dr. Wilbur N. Baumann as President
Dr. Kenneth B. Jones as Vice-President
Dr. Lewis Burdette as Secretary-Treasurer
Dr. Clifford Anderson of California, who had started the general practice of medicine in Fishing Creek, in lower Dorchester County, left that community after a stay of six weeks and returned to California. That community is still without a physician, and a vacancy for a general practitioner still exists in that community.

The successful bidder for the addition of a new surgical-X-ray-laboratory wing to the Cambridge-Maryland Hospital was one of our local contractors, Charles E. Brohawn & Brothers. This company has committed itself to completing the addition by December 1957.

## FREDERICK COUNTY MEDICAL SOCIETY

LOUIS R. SCHOOLMAN, M.D.

*Journal Representative*

The regular December meeting was held jointly with the Frederick County Dental Society on the 11th at the Francis Scott Key Hotel. Dr. David Everhart, president of the Dental Society, presided. The speaker of the evening was Dr. Daniel Lynch of Georgetown Dental School who spoke on oral infections and dental caries.

### Hospital News

The Medical Staff of the Frederick Memorial Hospital had its monthly meeting on December third. A case of a bleeding Meckel's diverticulum in a 5 week old infant was presented by Dr. Heldrich, pediatrician, Dr. Reid, roentgenologist, and Dr. Lea, surgeon. The case of a 6 month old child who died of viral pneumonitis within 24 hours of onset was presented by Dr. Powell, pediatrician.

A joint meeting of the medical, pediatric and surgical departments was held December 28th. Dr. Charles Conley spoke on intestinal obstruction.

# Necrology*

## William A. Fisher, Jr., M.D.
## 1874–1956

Personality is something that it is impossible to project by mere words on paper; it must be contacted to be really felt and appreciated. For this reason any Memoriam to Dr. Fisher is almost bound to fall short of the desired goal, and resemble the mere biographical resume which is the usual product.

William A. Fisher, Jr., was the youngest of four children of Judge William A. Fisher and Louise Este Fisher. He was born in Baltimore in 1874. From reasonably authentic stories of his youth, he early exhibited certain "Peck's Bad Boy" qualities of thought, action and personality which he carried through life. At St. Paul's School, Concord, N. H., he promptly acquired a nickname which many of his intimates used affectionately from then on,—"The Brat." To others, less closely associated, he was "Billie" or "Uncle Billie." Whatever the appellation, it was always used with affection; to know him was to love him. A man of small stature, he nonetheless would dominate any group of which he was a part. His merry twinkle, "joie de vivre," infectious grin and chuckle were at once disarming and contagious. He graduated from Princeton—in those days rather slightingly referred to as "the Country Club"—in 1896, and remained ever thereafter one of its most loyal alumni, rarely missing a Commencement Reunion or an important football game.

After graduating from Princeton he entered the Johns Hopkins Medical School, still in its infancy, and graduated as a doctor in 1900. He then went to the old Union Protestant Infirmary—always corrupted in parlance to the "U.P.I."—the mother of the present Union Memorial Hospital, of which Dr. Fisher, with certain others, might be called a founder, and throughout his professional life, remained intimately associated with it. It was as a house officer at the U.P.I. that he first came in close personal contact with Dr. J. M. T. Finney, an association of mutual respect and appreciation which was constant until Dr. Finney's death. Each one was called upon to administer to the other surgically.

It was at this time that I, then a less-than-teenager, first got to know Dr. Fisher, and to fall willingly under his spell. He had one of the earlier automobiles in Baltimore; a "steamer," in which you ignited the burner under the seat, waited a half-hour to get up the necessary steam pressure for operation, then mounted the seat and set forth, all the time hoping that the contraption would not blow up.

After finishing his hospital training, Dr. Fisher in addition to his own office, maintained an office association with Dr. Finney for many years; in fact, until in the due course of time, I finished medical school and hospital training, and then went in with my father, though even then Dr. Fisher's brass sign remained at the door for several years, until we moved the location of the office.

For one who never occupied a prominent teaching position, "Uncle Billie" exerted more influence on the lives of young surgeons than anyone that I ever came in contact with. His imprint is indelibly marked on the Union Memorial Hospital, and on countless young surgeons who trained there. No one could be more patient, helpful or understanding with a neophyte. Throughout the years he guided, tutored and counselled; he imparted of his sound, unexcelled judgment and faultless surgical technique; he exemplified principles of honesty, cheerfulness and courage in adversity, and tact and gentleness in the humane handling of patients. With every man who passed under his influence he sent a part of himself.

During World War I he went to France as a Captain with the Hopkins Base Hospital Unit—#18—but was soon detached, and thereafter served as the Assistant Consulting Surgeon of the A.E.F., for which critical assignment, more than well done, he emerged from the war as a Colonel, and was later given the Distinguished Service Medal. Some of us who served with him felt that a much more

* Memoir Committee: A. S. Chalfant, M.D., *Chairman*, John F. Hogan, M.D. and Robert H. Riley, M.D.

descriptive title, which he surely earned, would have been "Morale Officer."

A real sportsman throughout his life, being particularly interested in quail and duck shooting, and salmon fishing, he was the best "company" that anybody could have, no matter what age. He always exhibited the spirit (and outlook) of eternal youth. In the off hours of hunting or fishing, or after lunch hour at the Maryland Club, which he served as president for several years, he was always the first to produce a pack of cards, with a wicked twinkle in his eye, and suggest a game of bridge, gin-rummy or backgammon.

Master surgeon, judgment without peer, patient, willing teacher of young internes and residents, no one was ever more interested in the progress of those who trained under him, or did more to insure their future success. Throughout the profession he was known as the "Surgeons' Surgeon." He never wrote articles, he rarely if ever spoke at surgical meetings, he never contributed anything new or unusual to surgical research, technique or literature, but fellow-surgeons and former pupils throughout the United States often came to him for diagnosis, advice and care when an operation seemed indicated.

In 1906 he married Anne Baylor of Staunton Hill, Virginia. They had three children: William A., III, who follows his grandfather in the legal profession; Ellen, who married Dr. John E. Bordley, now head of the Eye, Nose and Throat department of the Johns Hopkins; and Elizabeth, an outstanding entomologist. There are four grandchildren. To these our sympathy and condolence go in their great loss.

Those of us in the medical profession here in Baltimore; in Maryland, and in the whole community have lost a confrère, friend, and example of life, who can never be replaced.

J. M. T. Finney, Jr., M.D.

## Egbert Laird Mortimer, Jr., M.D.

### 1904–1956

Dr. Egbert Laird Mortimer, Jr., a well known physician in Baltimore, died of cerebral hemorrhage on December 2, 1956, at the age of 52.

Dr. Mortimer was born in Baltimore and attended Saint John's College in Annapolis and the University of Maryland, from which he received his degree in Medicine in 1930. He interned at the Union Memorial Hospital and at the time of his death was associated with the Saint Agnes Hospital, Franklin Square Hospital, Maryland General Hospital and the University Hospital. He was a member of the Baltimore City Medical Society, the Medical and Chirurgical Faculty of Maryland and the American Medical Association.

Dr. Mortimer is survived by his wife, Mrs. Caroline Bushnell Lucius Mortimer, and two sons Egbert Laird Mortimer, 3rd and Henry Lucius Mortimer. His mother, Mrs. Egbert Laird Mortimer, Sr., and two sisters, Mrs. Robert Chenowith of Baltimore and Mrs. Carl Mathey of Davenport, Iowa, also survive him. His father was Dr. Egbert Laird Mortimer, Sr.

J. F. H.

## George Milton Boyer, M.D.*

### 1872–1956

Dr. George M. Boyer was born on May 22, 1872, in Damascus, Montgomery County, Maryland. He died of arteriosclerosis at his home on September 21, 1956, at the age of 84.

Dr. Boyer received his early education in the public schools of Montgomery County, with special work in Latin from the Darnestown Academy prior to entering Shenandoah College. Upon completion of his college work, Dr. Boyer taught school in Montgomery County until 1898. This same year he entered medical school and received the degree of Doctor of Medicine from the George Washington University in 1902. He entered the private practice of medicine in Washington Grove, remaining there until 1906 when he moved to Damascus.

When the United States entered World War I, even though Dr. Boyer was over 45 years of age, had a wife and four small children, and a full-time practice, his strong patriotic zeal prompted him to volunteer in the U. S. Army. He was commissioned a first lieutenant and rose to the rank of major within a year. In November of 1918, just one day after the signing of the Armistice, Dr. Boyer requested that he be released from the Army so that he might

* Presented by Dr. J. W. Bird to the Montgomery County Medical Society on October 16, 1956, to honor the passing of the last of its charter members and a past president.

return home to his practice where an epidemic of influenza was raging. The epidemic had already taken the lives of several neighboring physicians. Dr. Boyer continued to practice alone until 1935 when his son, Dr. McKendree Boyer, joined him in Damascus.

In 1941 Dr. Boyer suffered a cerebral thrombosis. He was able to continue in active practice until 1942 when he suffered a second cerebral thrombosis leaving him with a partial right hemiplegia. From this time on, his physical disability forced him into semi-retirement, but he continued to see a limited number of office patients until 1953.

Dr. Boyer was a Fellow of the American Medical Association, a member of the Southern Medical Association and a member of the Medical and Chirurgical Faculty of the State of Maryland. He was a member of the Montgomery County Medical Society, having served as president of this organization. He was on the staff of Frederick Memorial Hospital and Sibley Memorial Hospital. Since the staff of the Montgomery County General Hospital was not officially organized until 1947, Dr. Boyer was not a member of the hospital staff. However, while in active practice he was closely associated with the hospital and sent many patients there.

Dr. Boyer never turned down a house call. He prided himself in the fact that he would get to the patient regardless of the weather or road conditions. When the dog cart or sleigh could go no further, the trip was continued on horseback by jumping or cutting through fences. When the horse could travel no further, the trip was completed on foot. All this was done by him as a matter of Christian duty to help the sick. Dr. Boyer loved people and gave unsparingly of himself. His tremendous energies were always spent in helping others 16 to 20 hours each day. Financial remuneration meant nothing. Fees were ridiculously low. Office visits were 50 cents with medicines furnished. Few statements were rendered, then only once a year.

Dr. Boyer truly loved and was loved by the people of his community He was always a Christian gentleman in every sense of the phrase. He was of strong will and determination, yet a mild mannered, completely unselfish man. He was most tolerant, but once convinced a cause was right and just, he was fearless, relentless and untiring. He constantly and ably defended the under-privileged. He was keenly interested in religious and civic work. He was a Trustee of the Damascus Methodist Church for 50 years, a lay delegate to the Methodist Regional Conference for many years, and a Trustee of the Damascus School for over 47 years. Always interested in raising educational standards in the rural areas, one of his greatest thrills came in 1950 when, jointly with the late Dr. Edwin W. Broome, he broke ground for the new Damascus High School. Dr. Boyer served as a director and vice president of the Bank of Damascus from its founding in 1921 until his death. His organizational affiliations were numerous.

Dr. Boyer was of mixed French, English and German ancestry. He was the son of Milton and Elizabeth Purdum Boyer, and the great-great grandson of Casper Boyer, a French Hugenot who migrated to this country because of religious persecution. His great-great grandfather and great grandfather, Peter Boyer, both fought in the American Revolution as commissioned officers. When the war was over Peter Boyer moved to Damascus, then in Frederick County, on acreage still owned by his descendants. It was there that John Boyer, Dr. Boyer's grandfather, was born in 1790; his father, Milton was born in 1834; and he, George, was born in 1872.

Dr. Boyer is survived by his widow, Mrs. Annie M. Boyer; four children, Susan E. Boyer, Dr. McKendree Boyer, George W. Boyer and Mrs. Mary Boyer Cramer; and six grandchildren.

The epitaph on his tomb reads: "Diligent and faithful servant of God and his fellow man."

## Edward Sooy Johnson, M.D.
### 1886–1956

Dr. Edward Sooy Johnson passed away at the age of 70 on Christmas Eve at his home in Baltimore very suddenly while seated in his living room.

Dr. Johnson graduated from the University of Maryland Medical School in 1912. He interned and served as Resident at Saint Joseph's Hospital in Baltimore, at the termination of which he became a member of the staff of that hospital. He was a member of the Baltimore City Medical Society, the Medical and Chirurgical Faculty of Maryland, the American Medical Association and the Ameri-

can College of Surgeons, and he was a founder-member of the American Board of Surgery. He had wide hospital activities in many of the Baltimore hospitals, including Saint Joseph's, Mercy, Lutheran, Franklin Square, South Baltimore General, Church Home and University Hospitals. He served in his Alma Mater for many years as Associate Professor of Surgery. He also served in the Medical Corps of the Army in France in World War I, with Base Hospital Unit 42.

Born in Snow Hill, Maryland, he was very active in the Eastern Shore Society and was one of its past presidents.

He is survived by his wife, Mrs. Lillian Diehl Johnson, and his daughter, Miss Barbara Johnson.

J. F. H.

## CAMPING FOR CARDIAC CHILDREN

The Heart Association has a limited number of two-week camperships available for children, age 9 to 12 years, with a cardiac classification of I-A to II-B. The camp is especially geared to the limitations a child may have. The cost of the two weeks is $50.00. There are also a number of free camperships available. Campers must be referred by their physician.

Contact: Heart Association of Maryland
221 East 25th Street
Baltimore 18, Maryland

# Library

"Books shall be thy companions; bookcases and shelves, thy pleasure-nooks and gardens." *ibn Tibbon*

## LIBRARY CHATTER

LOUISE D. C. KING

*Librarian*

The Science and Art of Medicine are like a full grown tree: Its roots radiate in all directions for the nourishment necessary for growth and to hold erect a sturdy trunk, able to resist the adverse elements. The trunk itself symbolizes strength and dependability for growth put forth each year.

Each phase of "The Tree of Medicine" is represented in your library with the books written by or about men who have contributed to its structure. We have checked some of these names up to the nineteen twenties. What do you know of these men who have paved the way to the knowledge you take as a matter of course? Their work has become part of the roots and trunk of that vast "Tree of Medicine."

Hippocrates, Aristotle, Galen, Maimonides, Albertus Magnus, deChauliac, da Vinci, Avicenna, Paracelsus, Pare, Vesalius, Harvey, Malpighi, Willis, Sydenham, Leeuwenhoek, Bartholin, Harris, Ramazzini, Haller, Fahrenheit, Morgagni, Hales, The Hunters, Boerhaave, Monro, Heberden, Priestley, Lavoisier, Jenner, Laennec, McDowell, The Bells, Mott, Lister, Hodgkin, Basedow, Henle, Virchow, Addison, Sims, von Graefe, Bernard, Mendel, Koch, Paget, Pasteur, Klebs, Halsted, Roentgen, Pavlov, Cannon, von Economo, Banting and Best.

So much for the roots and trunk of our tree; what about the new shoots and leaves? They sparkle; they dazzle with their promise of life and hope. One cannot pick up a medical journal without seeing an account of some new phase, discovery or remedy. Let us not forget, it is not until the sap flows freely down into the roots and up into the trunk that this lovely yearly growth attains any degree of permanency.

We hope that you who may chance to read this short paragraph or two, will choose one or two names, on which we could send you material; or come in and read about the man, and his contribution to "The Tree of Medicine."

CHERRY CYPRESS OAK

FROM BADIANUS MANUSCRIPT

*An Aztec Herbal of the Year 1552*

# Health Departments

## BALTIMORE CITY HEALTH DEPARTMENT

### The Elimination of Diphtheria in Baltimore, 1920–1956

The effect of preventive medicine upon the course of disease and the practice of medicine is clearly demonstrated by the recent history of diphtheria in Baltimore. In 1920, for instance, there was no preventive agent available which could provide long-term protection against this disease. Under such a condition the average annual number of cases reported in the city during the period 1920–1924 was 1,387.

The Baltimore City Health Department in 1920 was called upon to examine 60,000 specimens for the presence of diphtheria organisms and provided approximately 29 million units of antitoxin, a preparation which was used either in the treatment of diphtheria cases, or to provide temporary protection to persons who had been in contact with the disease.

By 1925, the use of toxin-antitoxin was accepted as an effective preventive agent and the reported annual average incidence of cases of diphtheria during 1925–1929 was 946, a substantial reduction from the previous level recorded. During 1925, the number of specimens examined fell to 46,000 and the use of antitoxin declined to 20 million units.

*Reported Incidence of Diphtheria*
Baltimore City, 1920–1956

| Period | Average Annual Number of Cases | Average Annual Rate Per 100,000 |
|---|---|---|
| 1920–1924 | 1,387 | 184.9 |
| 1925–1929 | 946 | 120.5 |
| 1930–1934 | 287 | 35.3 |
| 1935–1939 | 143 | 14.7 |
| 1940–1944 | 101 | 10.8 |
| 1945–1949 | 202 | 21.6 |
| 1950–1954 | 17 | 1.7 |
| 1955 | 2 | 0.2 |
| 1956 | 1 | 0.1 |

In 1934, the City Health Department initiated the distribution of diphtheria toxoid, an effective long-term immunizing agent, and the final stage was set for the practical elimination of diphtheria as a disease in Baltimore. In 1955, there were but two cases of the disease reported, but at the same time 65,000 c.c. of a protective agent containing diphtheria toxoid were distributed to private physicians and clinics. The number of specimens submitted and examined for the presence of diphtheria organisms fell to 265, and the amount of antitoxin used was reduced to less than one million units.

The history of diphtheria constitutes a triumph of preventive medicine. This disease has been almost completely eliminated. Only one case in a transient family was reported in Baltimore in 1956. It will remain absent only if each person will learn to do his part in this preventive battle. For diphtheria the conquest is won if each and every child is inoculated at the ages of 4, 5, 6 and 18 months and again just before entering school. This places essential responsibility upon parents and upon physicians charged with the health care of infants.

Huntington Williams, M.D.

*Commissioner of Health*

## STATE DEPARTMENT OF HEALTH

### Sudden and Unexpected Death in Infancy and Childhood

In the study of infant and childhood accident fatalities, there has been a lot of discussion concerning the possibility of mechanical suffocation, or whether the child died as a result of sudden overwhelming respiratory infection or other disease.

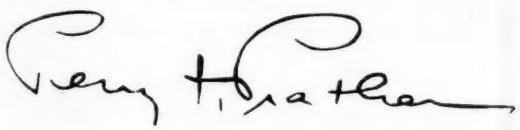
The May 1956, issue of "Pediatrics" contains a very timely article entitled "Sudden and Unexpected Death in Infancy and Childhood" by Dr. Lester Adelson and Eleanor Roberts Kinney, Ph.D. The length of the article prohibits reproduction here in its entirety. However, because of its import to those interested in the home accident prevention program, we are quoting below excerpts from the discussion and conclusions.

"Accidental mechanical suffocation by bedclothes, aspiration of gastric content or over-laying by an adult have been blamed traditionally for sudden death in infancy. Less than ten years ago attention was directed to the large number of infants less than

one year of age who were said to have died of accidental mechanical suffocation. . . . When an infant who was apparently well is found dead in bed, lying on its face or with its face covered by bedding or with gastric contents in the air passages, it is natural that the possibility of suffocation will be considered by persons who are uninformed about such matters. Several facts make this possibility untenable unless it is clear that there was mechanical interference with pulmonary ventilation, and that the nature of the interference was such that the infant probably could not have reacted to relieve the obstruction. Unless moribund or handicapped by a previously recognized defect in deglutition, an infant rarely will retain sufficient gastric content in its air passages to cause sudden death. Children whose death is known to have resulted from disease frequently regurgitate gastric content in the agonal period and may aspirate. Such an event is almost always the result rather than the cause of the fatal episode.

"The chief reason in the past for considering suffocation as the cause of death was the apparent absence of any other explanation. It can never be assumed that there is no other explanation unless proof that suffocation did occur is reasonably conclusive. Necropsies of infants, the victims of sudden and unexplained death, usually establish the presence of unsuspected disease. The fact that evidence of disease is not disclosed at necropsy cannot be construed to support the proposition that death resulted from an unnatural cause. Post-mortem examination of infants whose death was witnessed and who, by exclusion, are known to have died of disease rather than violence, frequently failed to disclose pathological evidence of the nature of the fatal disease or of the mechanism by which it caused death. . . .Although the actual lethal processes and mechanisms responsible for sudden death in early life are still obscure and not completely understood, the present study demonstrated *that mechanical asphyxia by bedclothes is not a serious consideration.* Proper dissemination of this information to the parents of the dead infants and to the general public has practically eliminated the notion in this area (Cleveland) that these deaths are accidental. Thus a real dividend of reassurance and peace of mind has been contributed to the community."

The above general conclusions have been checked with Dr. Russell S. Fisher, Chief Medical Examiner, who comments as follows: "We participated in the general study reported on above as one of four teams under the leadership of Dr. Sidney Farber of Children's Hospital of Boston of which Drs. Adelson and Kinney were one team. It is apparent that true suffocation is rare and that the most frequent cause of such deaths is overwhelming infection. Whenever possible in these sudden deaths, it is desirable to conduct complete post-mortem examinations to rule out contagious disease. Should this be impossible, it is desirable to conclude infection to be the cause of death rather than mechanical asphyxia since statistically this is more frequently true and the connotations with respect to negligence are so much less serious."



*Director*

STATE OF MARYLAND DEPARTMENT OF HEALTH

## MONTHLY COMMUNICABLE DISEASE REPORT

*Case Reports Received during 4-week Period, February 1–28, 1957*

| | CHICKENPOX | DIPTHERIA | GERMAN MEASLES | HEPATITIS, INFECT. | MEASLES | MENINGITIS, MENINGOCOCCUS | MUMPS | POLIOMYELITIS, PARALYTIC | POLIOMYELITIS, NON-PARALYTIC | ROCKY MT. SPOTTED FEVER | STREP. SORE THROAT INCL. SCARLET FEVER | TYPHOID FEVER | UNDULANT FEVER | WHOOPING COUGH | TUBERCULOSIS, RESPIRATORY | SYPHILIS, PRIMARY AND SECONDARY | GONORRHEA | OTHER DISEASES | DEATHS: Influenza and pneumonia |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Total, 4 weeks** | | | | | | | | | | | | | | | | | | | |
| **Local areas** | | | | | | | | | | | | | | | | | | | |
| Baltimore County | 72 | — | 1 | — | 3 | — | 29 | — | — | — | 25 | — | — | 4 | 27 | — | 2 | — | 10 |
| Anne Arundel | 9 | — | — | — | 1 | — | 1 | — | — | — | 1 | — | — | — | 7 | — | 1 | — | 3 |
| Howard | — | — | — | — | — | 1 | 4 | — | — | — | 1 | — | — | — | 2 | — | — | — | — |
| Harford | 3 | — | — | — | — | — | 1 | — | — | — | — | — | — | — | 3 | — | — | — | — |
| Carroll | 34 | — | — | — | — | — | 23 | — | — | — | 1 | — | — | — | 1 | — | — | — | 3 |
| Frederick | 4 | — | 1 | 7 | — | — | 10 | — | — | — | 1 | — | — | — | 9 | — | 1 | e-1 | 4 |
| Washington | 3 | — | 1 | — | — | — | 3 | — | — | — | — | — | — | 1 | 3 | — | — | t-1 | — |
| Allegany | 5 | — | — | 1 | 2 | 1 | 1 | — | — | — | 29 | — | — | — | — | — | 2 | — | 2 |
| Garrett | 1 | — | — | — | — | — | — | — | — | — | — | — | — | — | 1 | — | — | — | — |
| Montgomery | 16 | — | 4 | 1 | 9 | — | 39 | — | — | — | 15 | — | — | — | 3 | — | — | — | 5 |
| Prince George's | 11 | — | 1 | — | 3 | 1 | 34 | — | — | — | 9 | — | — | 1 | 6 | — | 1 | m-1 | 4 |
| Calvert | — | — | — | — | — | — | — | — | — | — | — | — | — | — | — | — | — | p-1 | — |
| Charles | — | — | — | — | — | — | — | — | — | — | — | — | — | — | — | — | — | — | — |
| Saint Mary's | 4 | — | — | — | 1 | — | 14 | — | — | — | — | — | — | 1 | — | — | — | — | 2 |
| Cecil | 1 | — | — | 2 | — | — | 1 | — | — | — | 2 | — | — | — | 4 | — | 3 | m-1 | — |
| Kent | — | — | — | — | 1 | — | — | — | — | — | 3 | — | — | — | — | — | — | — | — |
| Queen Anne's | 1 | — | — | — | 1 | — | 1 | — | — | — | — | — | — | — | 1 | — | — | — | 1 |
| Caroline | 2 | — | — | — | — | — | 1 | — | — | — | — | — | — | — | — | — | 7 | — | — |
| Talbot | — | — | — | — | — | — | — | — | — | — | — | — | — | — | 1 | — | 2 | — | 2 |
| Dorchester | — | — | — | — | — | — | — | — | — | — | — | — | — | — | 5 | — | — | — | — |
| Wicomico | 8 | — | — | 4 | 17 | — | 7 | — | — | — | — | — | — | 1 | 4 | — | 1 | — | 2 |
| Worcester | 1 | — | — | 2 | 3 | — | — | — | — | — | — | — | — | — | 3 | — | — | — | — |
| Somerset | — | — | — | — | — | — | — | — | — | — | — | — | — | — | 2 | — | — | — | — |
| Total Counties | 175 | 0 | 8 | 17 | 41 | 3 | 169 | 0 | 0 | 0 | 87 | 0 | 0 | 8 | 82 | 0 | 24* | | 38 |
| Baltimore City | 129 | 0 | 4 | 0 | 13 | 0 | 60 | 0 | 0 | 0 | 37 | 1 | 0 | 11 | 64 | 14 | 391 | — | 23 |
| **State** | | | | | | | | | | | | | | | | | | | |
| February 1–28 1957 | 304 | 0 | 12 | 17 | 54 | 3 | 229 | 0 | 0 | 0 | 124 | 1 | 0 | 19 | 146 | 14 | 415 | | 61 |
| Same period 1956 | 445 | 0 | 81 | 13 | 2093 | 8 | 298 | 0 | 0 | 0 | 119 | 1 | 0 | 12 | 168 | 30 | 401 | | 68 |
| 5-year median | 508 | 2 | 62 | 31 | 1300 | 5 | 248 | 1 | | 0 | 245 | 1 | 1 | 24 | 164 | 20 | 478 | | 81 |
| **Cumulative totals** | | | | | | | | | | | | | | | | | | | |
| **State** | | | | | | | | | | | | | | | | | | | |
| Year 1957 to date | 814 | 1 | 31 | 23 | 116 | 7 | 468 | 0 | 0 | 0 | 205 | 1 | 0 | 42 | 314 | 40 | 1174 | | 139 |
| Same period 1956 | 869 | 0 | 137 | 27 | 4108 | 13 | 616 | 1 | 0 | 0 | 224 | 1 | 0 | 38 | 377 | 58 | 1088 | | 190 |
| 5-year median | 1004 | 2 | 102 | 51 | 2300 | 13 | 469 | 2 | | 0 | 444 | 2 | 3 | 67 | 340 | 43 | 1248 | | 173 |

e = infectious encephalitis, etiology unknown.
m = meningitis, other than meningococcus.
p = paratyphoid fever.
t = tularemia.
* = total includes 4 cases reported from State Institutions.

# Book Reviews*

*Acknowledgment of all books received will be made in this column, and this will be deemed by us as full compensation to those sending them.*

**The Doctor's Marital Guide for Patients.** Dr. Bernard R. Greenblat. Two pamphlets: Catholic and Regular editions. Published by The Budlong Press, Chicago 25, Illinois. 88 pages. Copyright 1956.

In reviewing "The Doctor's Marital Guide for Patients" by Dr. Bernard R. Greenblat, I find that he has carried out the basic idea of this book very well. The basic idea is that normal men and women will get along better if they know how the unceasing activities of the sex organs and glands affect their daily vitality and vigor. The author is comprehensive in his material and he has written it in a manner that the average layman can understand. He has also stressed the Catholic viewpoint in a special addition. These monographs can well be recommended for those patients who are married or about to be married.

T. K.

**Textbook of Gynecology,** by Drs. Emil Novak and Edmund R. Novak—5th edition. The Williams and Wilkins Company, Publishers. 840 pages. Copyright 1956.

This latest edition of the "Textbook of Gynecology" by Emil Novak and Edmund R. Novak, is all inclusive in its material in relation to the female generative tract, including a chapter, "Disorders of the Female Urinary Organs." It has brought up to date many of the chapters, especially those of uterine cancer and genital tuberculosis. This book I can well recommend to Interns, Residents, General Practitioners, Gynecologists and Obstetricians.

T. K.

* The reviews here published have been prepared by competent authorities and do not represent the opinions of any official bodies unless specifically stated.

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## WOMEN'S MEDICAL SOCIETY

The Women's Medical Society of Maryland invites all women physicians, attending the Annual Meeting of the Medical and Chirurgical Faculty, to be its guests at a Cocktail Party on Wednesday, May 1, 1957, from 5:30 p.m. to 7:00 p.m. in room 218 at the Sheraton Belvedere Hotel, Charles and Chase Streets, Baltimore. For further information contact Dr. Mary E. Matthews, Secretary, 1637-A Waverly Way, Baltimore 12.

# Woman's Auxiliary Medical and Chirurgical Faculty

MRS. GERALD W. LEVAN, *Auxiliary Editor*

## EIGHTH ANNUAL CONVENTION OF THE WOMAN'S AUXILIARY

MRS. HOMER ULRICH TODD, SR.

The Eighth Annual Convention of the Woman's Auxiliary to the Medical and Chirurgical Faculty of the State of Maryland will be held at the Sheraton-Belvedere Hotel in Baltimore May 1 and 2, 1957.

The Annual State Convention is the culmination of the Auxiliary year. All State officers, Committee Chairmen and Component Presidents, accompanied by their elected delegates, are expected to attend the Convention.

The purpose of the State Convention is to review the work done the past year and judge its worth on both State and Component levels.

Our meeting will be held on Wednesday, May 1, at 9:30 A.M., followed by luncheon at 12:30 P.M. The Hon. Theodore R. McKeldin, Governor of Maryland, will be with us at that time. Other important guests will be Mrs. Paul C. Craig, the National President-Elect of the Woman's Auxiliary to the American Medical Association; Miss Margaret N. Wolf, Executive Secretary; Mrs. Edgar Quale, 4th Vice-President, both of the Woman's Auxiliary of the American Medical Association. Also the State Presidents of the following states will be present:

| | |
|---|---|
| Connecticut | Pennsylvania |
| Delaware | Rhode Island |
| District of Columbia | Virginia |
| New Jersey | West Virginia |

The Baltimore City Auxiliary is planning some social activities for the out-of-town guests on Thursday afternoon, May 2.

The Executive Board of the Auxiliary has reserved Parlor F on the second floor of the Sheraton-Belvedere Hotel for the use and convenience of all ladies attending the Convention. The parlor will be open on Wednesday, May 1, and Thursday, May 2, from 9:00 A.M. to 5:00 P.M. Members of the Auxiliary will act as hostesses. It is hoped you will feel free to use this parlor, as it has been reserved for your comfort and convenience.

Please come to the Convention. Consider your presence a personal obligation to your State Auxiliary.

You will enjoy seeing your old friends and meeting new ones.

## 1956–57 PUBLIC RELATIONS PROGRAM OUTLINE FOR COUNTY AUXILIARIES

With "Health is Our Greatest Heritage" as the theme for the Auxiliary this year, it is fitting that the activities of the Public Relations Committee be directed toward this objective. The efficacy of the committee depends upon its ability; first, to help the layman understand the functions, policies, and aims of the medical profession; and second, to make each auxiliary member aware of her responsibility to her community for the improvement of health and the advancement of medical service. Active participation in the entire Auxiliary program should be emphasized. It is important that the public relations chairman work as closely as possible with the program chairman.

Specific projects adopted by the Woman's Auxiliary to the A.M.A. for public relations this year:

I. American Medical Education Foundation
II. Today's Health
III. Safety
    1) Highway. 2) Home. 3) "Gems"—Baby Sitter Program.
IV. Mental Health
V. Community Health
    1. Voluntary Health Insurance.
    2. Emergency Call Plans.
    3. Survey of Health Facilities.
    4. Health Days.
    5. Rural Health.
    6. Rehabilitation.

VI. Civil Defense
VII. Recruitment
VIII. Science Fairs—Medical Exhibit Section

This committee should continue to cooperate with various health and educational organizations approved by the National, State, and County Medical Advisory Committees.

If assistance is needed please consult your State Public Relations Chairman.

*A reminder:* The physician's wife as a leader in health fields has a great influence on public opinion and should always remember that she is more often quoted, not as an individual, but as a physician's wife.

Mrs. F. Erwin Tracy
*National Chairman*
*Public Relations Committee*

## YOU . . . YOUTH . . . AND SCIENCE FAIRS

A triple-dividend insurance policy—guarding the future—and providing your medical society with benefits in

1—Career Counselling
2—Scientific Progress
3—Community Service

Science fairs, like county fairs which stimulated agricultural and industrial growth, develop America's greatest and most indispensable natural resource—its youth.

The medical society which sponsors a high school science fair aids and inspires talented youngsters, underwrites the years ahead, and strengthens its own profession by insuring a growing supply of well-trained scientists and technologists.

### Come to the Aid of the Fair

A science fair is an exhibition of scientific projects prepared by elementary and high school students for showing to their classmates, teachers, parents, and the public. Most local fairs affiliate with Science Clubs of America, a non-profit organization for the popularization of science, in order to receive its counsel and to qualify for the National Science Fair when finalists compete for national recognition.

Successful fairs require the assistance, advice, and financial backing of a local sponsoring group. Until three years ago only three fairs were sponsored by medical societies— their rewards in youth counselling and community relations were so great, however, that today the medical profession throughout the country is taking a spirited interest.

### A.M.A. House of Delegates Endorses Science Fairs

The medical profession's enthusiastic support of this program was accelerated by the House of Delegates of the American Medical Association at its 1956 Annual Meeting in Chicago when it adopted a resolution on science fairs. Introduced by the Indiana State Medical Association, the resolution urged:

"Whereas, the experience by our State in the 1955 Science Fair program has proven worth far more than its cost, from a public relations standpoint, and whereas, the sincere letters of appreciation from students, teachers, school officials and the public evidenced an entirely new perception of our medical organization, now therefore be it Resolved, that the American Medical Association . . . continue to use every resource at its command to bring the whole of organized medicine into active participation in this worthwhile and constructive program to encourage the youth of our nation to take a serious interest in the field of science as their career."

### The Stepping Stones to Youth Achievement in Science

1. The Local Science Fair is the showplace for youngsters to exhibit experiments, collections, and hobbies based on scientific principles. More than 187,000 students participated in the 1956 local fairs which were visited by almost 964,000 persons.

2. The Regional Science Fair is a composite of the winning exhibits from local fairs in the area. Each regional fair is a "semi-final" competition and the two winning students are rewarded with a trip to the National Science Fair. The 1956 regionals drew 31,240 exhibits from the preliminary local fairs and were visited by 718,990 persons.

3. The National Science Fair is the annual Mecca for all aspiring scientific youth. Here is the summit of success in high school science. Sponsored by Science Clubs of America, the National presents awards worth $2,500 in scientific equipment. At the 1956 National Science Fair, 213 boys and girls from

110 regional fairs in 39 states and the District of Columbia competed for top awards. The medical profession should note with appreciation that two of every five finalists in the National Science Fair in recent years are now studying medicine, medical technology, nursing, pharmacy, physical therapy, anatomy, psychology, bacteriology, chemistry, biology, and zoology.

How Science Fairs Are Growing—The growth of the National Science Fair, which reflects the comparable growth of local and regional fairs, has been phenomenal. The 1956 Fair, for example, is estimated to be over thirteen times larger than the first exposition held just seven years earlier.

## What Your Medical Society Can Do

There are still a great many areas which do not have adequate support for their scientific fairs (nine states were not represented at the National Science Fair in 1956). A great number of communities would like to organize local and regional fairs but they, too, lack the necessary backing of a civic group.

Check with your local high school science instructors and principals for possible sponsorship of a science fair. Then for information on

How to organize
Rules for exhibits
Who may enter
Standards of judging
Types of exhibits
Awards

Write to: Science Clubs of America
1719 N Street, N.W.
Washington 6, D.C.

## The Time for Action

Since most science fairs are held in late winter and early spring, medical societies should contact their local schools to offer their assistance as soon as possible after the school year gets underway in the autumn. Many of the students prepare their exhibits as part of their science class work or as a project in their school science club. Undoubtedly, a greater number of young scientists would be stimulated to construct exhibits if they were assured of a science fair in the spring where they could display their work and compete for awards.

Almost all fairs are concluded by late April so the winners can prepare for their competition in the National Science Fair for the honors awarded by Science Clubs of America and the American Medical Association.

Your investment in science fairs will bring increasing dividends for three beneficiaries. Compute the maximum benefits:

You = Community Service
Youth = Career Counselling
Science Fairs = Scientific Progress

### SPECIAL AMA AWARDS

The American Medical Association presents four citations—two "firsts" and two "honorable mentions"—at the annual National Science Fairs to the students with the best exhibits in the basic medical sciences. Their selection is made by an AMA-appointed committee of physicians, and the two top winners are guests of the AMA at its Annual Meetings. These awards are in addition to those presented by Fair officials in the broader categories of biological and physical science.

# COMING MEETINGS

*APRIL 1957*

OTOLARYNGOLOGICAL SECTION, B.C.M.S.

Tuesday, April 9, 1957, 6:30 P.M. — Johns Hopkins Club

WOMAN'S AUXILIARY TO THE BALTIMORE CITY MEDICAL SOCIETY

Wednesday, April 10, 1957, 11:00 A.M. — 1211 Cathedral Street

COMMITTEE FOR THE STUDY OF PELVIC CANCER

Thursday, April 18, 1957, 5:00 P.M. — University Hospital, Room M 71

NEUROPSYCHIATRIC SECTION, B.C.M.S.

Thursday, April 11, 1957, 8:30 P.M. — 1211 Cathedral Street

SECTION ON GENERAL PRACTICE, B.C.M.S.

Thursday, April 18, 1957, 9:30 P.M. — 1211 Cathedral Street

JOINT COMMITTEE ON MATERNAL MORTALITY, CITY HEALTH DEPT. AND B.C.M.S.

Thursday, April 25, 1957, 4:00 P.M. — 1211 Cathedral Street

ANNUAL MEETING MEDICAL AND CHIRURGICAL FACULTY

May 1, 2, 3, 1957 — 1211 Cathedral Street

All meetings are held in the Medical and Chirurgical Faculty Building, 1211 Cathedral Street, Baltimore, Md., unless otherwise designated.

GILL MEMORIAL EYE, EAR and THROAT HOSPITAL

announces

THIRTIETH ANNUAL SPRING CONGRESS

in

OPHTHALMOLOGY, OTOLARYNGOLOGY, and ALLIED SPECIALTIES

April 1st, through April 6th, 1957

Patrick Henry Hotel

Roanoke, Virginia

Scientific Sessions and Clinics—9:00 A.M.–1:00 P.M.
2:00 P.M.–6:00 P.M.

Luncheon daily 1:00–2:00 P.M.